DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF HEALTH PLAN OVERSIGHT
DIVISION OF PLAN SURVEYS

ROUTINE SURVEY OF DENTAL PLAN

FINAL REPORT

JAIMINI HEALTH, INC.

ISSUED TO PLAN MAY 15, 2003

ISSUED TO PUBLIC FILE MAY 25, 2003

Jaimini Health Inc.
Final Report of Routine Dental Survey
May 15, 2003

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I. INTRODUCTION

The Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), Section 1380, requires the Department of Managed Health Care (the "Department") to conduct a medical survey of each licensed health care service plan at least once every three years. The medical survey is a comprehensive evaluation of the Plan's compliance with the Knox-Keene Act. The subjects covered in the medical survey are listed in Health and Safety Code Section 1380 and in Title 28 of the California Code of Regulations, Section 1300.80.[1]

Generally, the survey reviews the major areas of utilization management, access and availability, grievances and appeals, quality management and in the following specific categories:

- Procedures for obtaining health care services;
- Procedures for reviewing and regulating utilization of services and facilities;
- Procedures to review and control costs;
- Peer review mechanisms;
- Design, implementation and effectiveness of the internal quality of care review systems;
- Overall performance of the plan in providing health care benefits; and
- Overall performance of the plan in meeting the health needs of enrollees.

This Final Report summarizes the findings of the Routine Dental Survey of Jaimini Health, Inc. (the "Plan"). The Plan submitted pre-survey documentary information to the Department on November 29, 2002. The on-site review of the Plan was conducted on December 9 to 12, 2002.

As part of the survey process, the survey team conducted interviews and examined documents at the Plan 's administrative offices in Sacramento, CA. The names of the survey team members are listed in Appendix A. The names and titles of persons who were interviewed at the Plan are listed in Appendix B.

The Preliminary Report of the survey findings was sent to the Plan on February 7, 2003. All deficiencies cited in the Preliminary Report required follow-up action by the Plan. The Plan was required to submit a response to the Preliminary Report within 45 days of receipt of the Preliminary Report. The Plan submitted its response on March 27, 2003.

The Final Report contains the survey findings as they were reported in the Preliminary Report, a summary of the Plan's Response and the Department's determination concerning the adequacy of the Plan's response. The Plan is required to file any modification to the Exhibits of the Plan's licensing application as a result of the Plan's corrective action plans as an Amendment with the Department. **If the Plan wishes to append its response to the Final Report, please notify the Department before May 25, 2003.**

[1] References throughout this report to "Section ____" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as amended [California Health and Safety Code Section 1340 *et seq*. ("the Act"). References to "Rule ____" are to the regulations promulgated pursuant to the Act [Title 28 of the California Code of Regulations, beginning at Section 1300.43. ("the Rules")].

Any member of the public wanting to read the Plan's entire response and view the Exhibits attached to it may do so by visiting the Department's office in Sacramento, California after May 25, 2003. The Department will also prepare a Summary Report of the Final Report that shall be available to the public at the same time as the Final Report.

One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost. The final report to the public will be placed on the Department's website: www.dmhc.ca.gov.

The Plan may file an addendum to its response anytime after the Final Report is issued to the public. Copies of the addendum also are available from the Department at cost. Persons wanting copies of any addenda filed by the Plan should specifically request the addenda in addition to the Plan's response.

Pursuant to Health and Safety Code Section 1380(i)(2), the Department will conduct a Follow-up Review of the Plan within 18 months of the date of the Final Report to determine whether deficiencies identified by the Department have been corrected. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1).

Preliminary and Final Reports are "deficiency" reports; that is, the reports focus on deficiencies found during the medical survey. Only specific activities found by the Department to be in need of improvement are included in the report. Omission from the report of other areas of the Plan's performance does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these activities or may not have obtained sufficient information to form a conclusion about the Plan's performance.

II. OVERVIEW OF PLAN OPERATIONS AND HEALTH CARE DELIVERY SYSTEM

The following summary is based on information submitted to the Department by the Plan in response to the Pre-Survey Questionnaire:

Date Plan Licensed	1983	
Type of Plan	Specialty Plan	
For profit/Non-profit Status	For Profit	
Service Area(s)	See Appendix C	
Number of Dentists – Healthdent of California	**Primary Care Dentists**	**Specialty Dentists**
	227 contracted facilities	The Plan does not cover any services provided by specialists. The Plan offers a separate orthodontic benefit in limited areas. If the PCD refers the enrollee to a specialist, the Plan reimburses the enrollee $50.00 towards the cost of the initial consultation.
Number of Dentists – PrimeCare Dental Plan	**Primary Care Dentists**	**Specialty Dentists**
	304 contracted facilities	353

	Product Lines	Enrollees
Number of Enrollees as of January 2003	Commercial – Healthdent of California	7,105
	Commercial – PrimeCare Dental Plan	4,416
	Total	**11,521**

A. Organizational Background and Structure

The Plan was founded in 1983 as Healthdent of California, Inc., a Knox-Keene-licensed, for-profit, staff-model managed dental care plan. The Plan subsequently expanded throughout California as a mixed-model (staff and direct contract) managed dental plan. In 2000, the Plan was placed in receivership because of its deteriorating financial performance. In late 2000,. Mohender Narula, DMD, the current President and CEO, formed Jaimini Health, Inc., in order to purchase Healthdent of California, Inc.

On January 1, 2001, Jaimini Health, Inc. acquired the name, license and book of business of Healthdent of California, Inc. However, it did not acquire the dental clinics. In October 2001, Jaimini Health Inc. acquired PrimeCare Dental Plan, Inc. a dental managed care plan that is based primarily in six counties within Southern California.

The Plan's current Board of Directors consists of the President/CEO, a co-owner of the Plan, the Dental Director, the Chief Operating Officer and several outside directors. The Board of Directors' charter mandates that the Board meet at least quarterly. A review of the Board minutes revealed that meetings have been held more frequently over the past year.

The key employees of the corporation include:

- Mohender Narula, DMD — President, Chief Executive Officer, and Director
- Minakshi Narula, DDS — Vice President and Director
- Carolyn Brodt, MPH — Secretary and Chief Operating Officer
- Richard White, DDS — Dental Director
- Mahesh Manchandia, CPA — Senior Financial Accountant
- Mahmood Siddiqui — Plan Accountant
- Cindy Semkiw — Director of Provider and Member Relations

B. Delivery Model

Arrangements for Obtaining Specialty Care
Specialist services are defined as endodontics, orthodontics, periodontics, pedodontics or oral surgery. The Plan has developed specialty referral criteria noted in the Jaimini QA Manual and the two Provider Handbooks. While the Plan does not require prior authorization of specialist referrals, it does require that all requesting providers submit the monthly Specialty Referral Forms. The Plan indicated that specialty referrals are used as encounter data to track and trend

utilization patterns. The Department, however, did not find any reports that indicate the Plan is trending utilization patterns.

Healthdent

The Healthdent product has 10 individual plans and six group plans. All of these plans cover a specified set of services when a participating PCD provides the services. Each enrollee selects a PCD at the time of enrollment and receives all dental services through that PCD. Services provided by specialists are not covered, except in the following two instances:

1. If the PCD refers the enrollee to a specialist, the Plan reimburses the enrollee $50.00 towards the cost of the initial consultation;

2. If the enrollee lives in an area in which there are participating orthodontists, the enrollee may choose to purchase a separate orthodontia benefit. The orthodontia benefit covers a defined set of usual and customary services over a 24-month period at a reduced fee-for-service fee schedule with a maximum allowable subscriber fee.

Although services provided by a SCD are not covered under the Healthdent benefit package, Jaimini has signed agreements with specialists who have agreed to provide Healthdent enrollees discounts on their fees. Enrollees can choose whether or not to use these specialists for services that their PCDs cannot provide. This discount arrangement is analogous to a full-service health plan arranging for discounts at health clubs for their enrollees, even though health club services are not a covered benefit.

PrimeCare

The PrimeCare product offers 15 individual plans and 2 group plans. All of these plans cover a specified set of services when such services are provided by participating PCDs and SCDs. According to the PrimeCare Evidence of Coverage and Disclosure Form, the enrollee must be referred by the PCD to the specialist and the referral must be approved by the Plan. Staff members stated, however, that this was a notification requirement, not a prior-authorization process and they do not approve or deny specialist services.

The PrimeCare Evidence of Coverage and Disclosure Form states that specialty services include orthodontia, when provided by participating SCDs. It also states that orthodontic "extended treatment, over 24 months, is at the usual and customary fee of the Plan orthodontist."

Additionally, the Plan reimburses a flat rate of $50.00 to enrollees who request a second opinion and can demonstrate why a participating PrimeCare dentist cannot provide the second opinion.

- **Arrangements for Obtaining Emergency Services**

For Healthdent and PrimeCare, emergency services are provided by the enrollee's PCD. The Plan requires that the PCD arrange for emergency services to be available twenty-four (24) hours a day, three hundred sixty five (365) days per year, including vacation periods and other times that the provider's office(s) may be closed. The Plan provides enrollee subscribers with identification (ID) cards describing how to obtain emergency services. The ID card instructs

enrollees to "contact your PCD at the phone number listed on the front of this card; if you are unable to reach your PCD in an emergency during normal business hours, call Enrollee Services at… for instructions. If after normal business hours, you may seek emergency dental service from any licensed dentist. Please refer to your Certificate of Coverage and Plan Schedule."

The emergency services provisions of the Healthdent Subscriber Group Contract and PrimeCare Evidence of Coverage are shown below.

Table 1 Emergency Care Access

	Healthdent Subscriber Group Contract (SGC)	PrimeCare Evidence of Coverage (EOC)
Definition	Palliative Treatment is an emergency dental procedure performed by a dentist to temporarily alleviate or relieve acute pain, discomfort, or distress, but it does not provide a definite cure.	Includes covered services to alleviate severe pain or other symptoms or to diagnose and treat an unforeseen illness or injury that a reasonable person under the circumstances would believe could lead to serious jeopardy or impairment of health if not treated immediately.
Emergency Access inside of the service area	Emergency health care services are available at each provider office 24 hours a day, seven days a week.	Emergency dental care is available to an enrollee 24 hours a day, 7 days a week through the provider's office that the enrollee selected.
Emergency Access outside of the service area	The Plan does not cover emergency palliative treatment by a non-Plan provider except to the extent of $50 if the Plan-appointed provider was not available within 30 road miles of the enrollee in need of emergency palliative treatment.	An enrollee requiring emergency dental care, while more than 50 miles from his or her selected provider, may have emergency services rendered by any licensed dentist in the location where the emergency occurs.
Emergency Coverage	The Plan does not cover emergency palliative treatment by a non-Plan provider except to the extent of $50 if the Plan-appointed provider was not available within 30 road miles of the enrollee in need of emergency palliative treatment. Upon application in writing accompanied by a statement from the non-Plan provider that emergency palliative treatment was given to the enrollee, the Plan will directly reimburse the subscriber member or the enrollee.	The Plan reimburses up to $50 per year per enrollee for emergency care rendered by a non-participating dentist upon presentation of a detailed statement from the treating dentist indicating all services provided. The enrollee is required to submit the detailed statement to the Plan within 60 days of services rendered. The enrollee is required to return to his or her selected provider for further treatment.
Limitations	None	$50 per year, per enrollee

Note: The payment to the enrollee for emergency services when the enrollee is not in geographic proximity to the PCD is not a reimbursement for the services *per se* but a way of compensating the enrollee for not having access to the discounted fee schedule through a participating PCD.

- **Risk Assumption for Health Care Services**

CONTRACTED FACILITIES/ENROLLMENT

	Primary Care Dental Practices*		Enrollees*		
	Number	% of PCDs	Number	% of Enrollees Under Care	Reimbursement Method
PrimeCare PCD– Direct Contracts	304	100%	4,416	NA	Capitation from Plan and Co-payments from Enrollees
Healthdent PCD – Direct Contracts	227	100%	7,105	NA	Access Plans: Co-payments from Enrollees Prepaid Dental Plans: Capitation from Plan and Co-payments from Enrollees
Total	531	100%	11,521	100%	

*Enrollment as of January 2003. Primary care dental practices as of December 2002. Specialty dental practices as January 2003.

Healthdent

The Plan pays participating Healthdent PCDs a capitation and/or a brokerage fee, depending on the type of plan.

- For four individual access plans, Jaimini pays a brokerage fee of 40% of the annual premium at the beginning of each contract year and no additional compensation.
- For three individual access plans, Jaimini pays a brokerage fee of 31% of the annual premium at the beginning of each contract year and no additional compensation.
- For three individual prepaid dental plans, Jaimini pays a brokerage fee of 10% of the annual premium at the beginning of each contract year and 47% of the monthly premium each month.
- For six group prepaid dental plans, Jaimini pays 47% of the monthly premium each month.

Additionally, the Plan reimburses $20 to a participating PCD for examination of a Healthdent enrollee who has been referred by the enrollee's PCD for a second opinion. There is no charge to the enrollee for a second opinion by another Healthdent dentist.

PrimeCare

The Plan reimburses participating PrimeCare PCDs on the same basis for all 17 plans. The PCD receives a brokerage fee of 20% of the annual premium at the beginning of the contract year and 20% of the monthly premium each month.

C. Delegated Functions and Plan Oversight Activities

The Plan does not delegate any functions to dental practices or any other organization for either product. The Plan does not delegate any oversight activities.

D. Plan Operational Functions

- ***Utilization Management***

The Plan's Utilization Management (UM) program is under the direction of the Dental Director, who is responsible for the development, evaluation and recommendations for improvement of all quality assurance activities. Utilization activities are reported to the Quality Assurance Committee (QAC) on a quarterly basis and reviewed annually for evaluation and recommendations for improvement. The functions of the QAC include the reporting of general dental services rendered and the tracking of specialty-care referrals.

The Quality Assurance (QA) Manual outlines the Plan's policies, but it does not specify the procedures for implementing these policies.

Dental care guidelines are developed with the participation of actively practicing dental providers, both contracted and non-contracted, who are also members of the Quality Assurance Committee and Peer Review Committee.

The Plan does not conduct prospective, concurrent, or retrospective review of dental services. Upon execution of a contract between the Plan and the provider, each provider facility receives a Provider Handbook that describes the purpose of utilization management and the guidelines the provider is expected to employ in determining treatment. Although both the PrimeCare provider agreement and the subscriber agreement state that the Plan is responsible for reviewing and approving referrals to specialists, the staff admitted that there is no formal review of the referral process and the Plan issues neither approvals nor denials.

The Plan tracks Healthdent PCD utilization and PrimeCare PCD and SCD utilization through the encounter forms that the participating dentists send to the Plan on a monthly basis. The Plan tracks Healthdent specialty referral utilization through the required PCD referral reporting. These encounter data are aggregated and submitted to the QAC on a quarterly basis.

- ***Access and Availability***

Plan enrollees may obtain covered services from any dentist on the panel of contracted providers. Enrollees are encouraged to select a provider at the time of enrollment; however, if a provider is

not selected, the Plan assigns a provider based on the location of the enrollee's home. An enrollee may request a change to another provider by telephoning or writing the Plan.

The Plan has a process in place for notifying enrollees of the termination of assigned providers 30 days prior to the termination. Such notification includes information about the termination, assignment of a new provider and information on how to contact the Plan provider and how to request a transfer to another provider of the enrollee's choice.

The Plan collects data on dental practices by specialty rather than on the number of dentists. Therefore, the Plan cannot accurately calculate the ratio of enrollees to practitioners. However, the ratio of enrollees to primary care dental practices can be calculated. The Plan does not have any mechanisms, such as a GeoAccess program, for evaluating the adequacy of their provider network against the Knox-Keene requirements for the ratio of PCDs to enrollees and the geographic accessibility of PCDs.

As shown in Table 2 below, 304 PCDs currently participate in PrimeCare. This is an overall ratio of 1 PCD to 12 enrollees. There are participating PCDs in all counties. SCPs are available in all counties as well, with the exception that there are no endodontists in San Bernardino County and no pedodontists in Ventura County.

There are 227 Healthdent primary care dental practices statewide. This is an overall ratio of 1 PCD to 31 enrollees. There are seven counties in which there are neither Healthdent enrollees nor Healthdent providers. There are 28 counties in which there are Healthdent enrollees and no primary care dental practices.

Table 2: PrimeCare Participating Dentists by County*

County	Enroll-ment	General	Endo-dontist	Oral Surgeons	Ortho-dontist	Pedo-dontist	Perio-dontist
Los Angeles	2654	29	26	42	48	22	45
Orange	921	37	9	24	24	3	2
Riverside	198	18	5	5	7	4	5
San Bernardino	75	19	0	1	13	3	1
San Diego	0	18	1	28	17	2	6
Santa Barbara	10	0	0	0	0	0	0
Ventura	508	3	1	2	3	0	4
Bad Zips	50						
Total	4416	304	45	102	112	34	63

*Based on Provider Listings for Primary Dentist May 2002, Specialist Listing July, 2001

Table 3 Healthdent Participating Dentists by County**

County	Enrollment	General Dentist	Endo-dontist	Oral Surgeons	Ortho-dontist	Pedio-dontist	Perio-dontist
Alameda	68	6	0	0	1	0	1
Alpine	0	0	0	0	0	0	0
Amador	21	0	0	0	0	0	0
Butte	416	3	0	0	1	0	0
Calaveras	13	0	0	0	0	0	0
Colusa	50	0	0	0	0	0	0
Contra Costa	39	1	0	3	0	0	1
Del Norte	0	0	0	0	0	0	0
El Dorado	70	0	0	1	2	0	0
Fresno	54	1	0	0	1	0	1
Glenn	69	0	0	0	0	0	0
Humboldt	1	0	0	0	0	0	0
Imperial	0	0	0	0	0	0	0
Inyo	0	0	0	0	0	0	0
Kern	7	0	0	0	0	0	0
King	4	0	0	0	0	0	0
Lake	4	0	0	0	0	0	0
Lassen	3	0	0	0	0	0	0
Los Angeles	275	106	10	14	28	5	23
Madera	15	0	0	0	0	0	0
Marin	15	0	0	0	1	0	0
Mariposa	10	0	0	0	0	0	0
Mendocino	5	0	0	0	0	0	0
Merced	88	1	0	0	0	0	0
Modoc	0	0	0	0	0	0	0
Mono	0	0	0	0	0	0	0
Monterey	1	0	0	0	0	3	0
Napa	6	0	0	0	0	0	0
Nevada	83	0	0	0	0	0	0
Orange	42	19	2	5	11	0	3
Placer	283	2	0	0	2	0	3
Plumas	130	0	0	0	0	0	0
Riverside	161	12	0	0	4	0	2
Sacramento	2960	14	0	0	4	0	0
San Benito	1	0	3	2	0	0	6
San Bernardino	127	17	2	0	4	0	0
San Diego	292	15	4	4	16	0	0

County	Enrollment	General Dentist	Endo-dontist	Oral Surgeons	Ortho-dontist	Pedio-dontist	Perio-dontist
San Francisco	419	6	0	0	2	0	0
San Joaquin	186	2	0	0	2	0	0
San Luis Obispo	3	1	0	0	0	0	0
San Mateo	49	5	0	0	0	0	0
Santa Barbara	2	0	0	0	0	0	0
Santa Clara	22	4	2	1	1	0	1
Santa Cruz	4	0	0	0	4	0	0
Shasta	8	1	0	0	1	0	0
Sierra	0	0	0	0	0	0	0
Siskiyou	4	0	0	0	0	0	0
Solano	95	2	0	1	1	0	0
Sonoma	25	0	0	5	2	0	0
Stanislaus	247	2	0	0	1	0	0
Sutter	25	1	0	0	0	0	0
Tehama	22	0	0	0	0	0	0
Trinity	2	0	0	0	0	0	0
Tulare	4	0	0	2	0	0	0
Tuolumne	31	0	0	0	0	0	0
Ventura	29	4	0	1	7	0	1
Yolo	526	2	0	0	0	0	0
Yuba	5	0	0	0	0	0	0
Missing Zip Codes	84						
Total	7,105	227	23	39	96	8	42

*Enrollment as of January 2003. Primary care dental practices as of December 2002. Specialty dental practices as January 2003.

The Plan has adopted the following provider appointment availability and waiting-room time standards.

Table 4 Appointment and Waiting Room Time Standards

Type of Services	Standard
Emergency Care	Same day or within 24 hours
Urgent Care	Same day or within 24 hours
Non-urgent Care	4 weeks

Preventive Care	4 weeks
Waiting-room Time	30 minutes
After-hours Care	Timely response
Telephone Access	None
Call Wait Times	N/A

On a quarterly basis, the Plan requires participating providers to self-report the availability of appointments and wait times via the Accessibility Survey. The Plan monitors the submission of these surveys via the Access Report. Staff members analyze the Access Report to identify providers that "deviate from the norm." According to the Dental Director, deviation from the norm is defined as not meeting one or more of the above-listed accessibility standards. The Plan has a process to follow up with each facility that deviates from the norm.

In addition to reviewing the Access Report, the Quality Assurance Committee (QAC) oversees accessibility and availability via the following:

- Enrollee Services Transfer Logs
- Enrollee Grievances
- Facility Site Reviews

- ***Grievance and Appeals***

The Plan's Dental Director has primary responsibility for maintaining the Plan's written grievance procedures; for reviewing the operation of the Plan's Grievance and Complaint System; for using any emergent patterns of grievances associated with quality-of-care issues to effect procedural improvements; for training staff personnel regarding the grievance processing and for conducting periodic on-site audits.

The Plan has a process in place for recording complaints/grievances in a telephone log. Each telephone or written complaint is reviewed, investigated and resolved by the Dental Director. Plan policy also requires an independent orthodontist auditor to review complaints relating to orthodontic services. For each grievance/complaint, the Dental Director completes the Grievance Tracking Record with information on enrollee allegations, resolution of the case, a summary tracking record of the provider and other enrollee data. In addition to sending an acknowledgement letter upon receipt of a grievance, the Dental Director also sends a written letter outlining findings and resolution within 30 days. The acknowledgment letter includes notice of the enrollee's entitlement to direct access to DMHC. The resolution letter reiterates the entitlement of the enrollee, as appropriate, to direct access to DMHC.

The grievance procedure also requires the Plan to expedite the review of grievances in cases involving an imminent and serious threat to the health of the patient. When the Plan has a case requiring expedited review, it immediately informs the enrollee in writing of his/her right to notify the Department (DMHC). The Dental Director sends a written statement regarding the disposition and pending status of the grievance within three days of receiving the grievance.

The written grievance procedure does not specify that an appropriately licensed dentist with the appropriate clinical knowledge and expertise, who was not involved in the initial decision-making/denial, will be consulted to review and make the determination of an appeal or contested claim.

The Grievance Committee comprises the Dental Director, the Chief Operating Officer and the Grievance Coordinator/Member Service Representative. In order to identify systemic problems, the Committee meets monthly to review telephone logs, grievances/complaints and enrollee requests for transfer.

The Dental Director presents all enrollee complaints received during the previous three months to the Plan's QAC at its quarterly meetings. The Quarterly Summary of Enrollee Complaints, records of monthly Staff Meeting for Grievance Process minutes, monthly Complaint/Grievance Recap and all individual Grievance Tracking Records are presented to the QAC and are reflected in the QAC meeting minutes.

Minutes of the QAC meetings, along with comments and recommendations, are forwarded to the Board of Directors for review. A copy of the Board of Director's Meeting Minutes is then returned to the QAC with comments and statements of actions taken. At subsequent QAC meetings, the Dental Director reports on follow-up actions and unresolved complaints.

The written grievance procedure and the materials provided to enrollees identify alternatives to filing a grievance, which include contacting the Department; requesting expedited review for cases involving an imminent and serious health threat; asking the Plan to arrange for voluntary mediation with each party sharing equally in the costs of mediation; appealing to the Plan's Board of Directors; and, after participating in the Plan's grievance process for at least 30 days, submitting a grievance to the Department.

The Plan does not have an established system for receiving Department contacts regarding urgent grievances on a twenty-four hours a day, seven days a week basis. Plan officials state that the Plan currently does not approve, modify or deny care, nor does it pay any specialty or provider claims. Therefore, it is the opinion of the Plan that it does not need to establish a system that provides for receipt of DMHC contacts regarding urgent grievances twenty four hours a day, seven days a week.

The Plan does not delegate any of its grievance process functions to other organizations.

- ***Quality Management***

The Plan's Quality Assurance (QA) Manual describes the scope of the QA program, which includes general dentistry and orthodontics. The required QA activities that are described in the QA Manual include:

- Peer review for issues of appropriateness of care and technical quality of care by the QA Committee;
- Investigation by the Dental Director of all quality-related grievances filed with the plan;
- Credentialing and recredentialing of providers;
- Periodic audits of participating dentists' and orthodontists' facilities and dental records.

The QA Program goals and objectives are articulated in the QA Work Plan.

The Plan's QA Program is focused on the examination of offices (site surveys) of general dentists and orthodontists as well as the identification, investigation and resolution of potential quality issues. It does not address population-based quality issues, such as adequacy of preventive dental care in the pediatric and adult populations.

The Dental Director is responsible for the QA Program and serves as chairperson of the QAC. The Provider Relations representatives and dental consultants provide administrative support to the QA Program.

The QAC, which also serves as the Peer Review Committee, reports to the Board of Directors, according to the QA Manual. The organization chart, however, shows that the QAC reports to the CEO/President, who reports to the Board of Directors.

The QAC is responsible for:

- Peer review issues of appropriateness of care and technical quality of care for cases and issues identified by the Dental Director;
- Oversight of the handling of quality-related grievances filed with the Plan; and
- Review of the results of periodic audits of participating dentists' and orthodontists' facilities and dental records.

The only quality assurance activities associated with specialists are the credentialing of participating PrimeCare specialists and the investigation of potential quality issues for PrimeCare specialists. Since the Plan does not cover specialist services or contract with specialists for services covered by the Healthdent product, there are no quality activities associated with specialists for this product.

The Plan credentials PCDs and specialists, including orthodontists, for its PrimeCare product. For the Healthdent product, the Plan credentials only the general dentists. However, the Director of Provider and Member Services collects copies of licenses, DEA certificates and insurance information for all of the specialists with whom the Plan has agreements for providing discounts on their fee schedules for Healthdent enrollees. The Plan does not, however, put them through the full credentialing process because the Plan does not have contracts with these individuals to provide services under the subscriber contracts.

Other than a general description in the QA Manual, there are no written policies and procedures for credentialing and recredentialing participating dentists. At the time of credentialing, the Plan undertakes the following:

- Verification that the practitioner holds a current, valid California dental license;
- Query to the National Practitioner Data Bank;
- Query to the Health Care Practitioner Data Bank; and
- Acquisition of copies of Conscious Sedation permits and General Anesthesia permits

According to the QA Manual, recredentialing consists of annual verification of the California dental license. A review of five credentialing files showed that in only one instance had the practitioner's license been verified in two consecutive years.

The Plan does not delegate any quality functions to other parties.

III. SUMMARY STATUS OF DEFICIENCIES

The following section contains the status of the deficiencies based on the Department's review of the Plan's Preliminary Report response. Unless otherwise noted, those deficiencies that have not been fully corrected within the 45-day requirement will be reviewed for full correction at the time of the Follow-up Review.[2]

For any deficiency(ies) where the Department finds that the response to the Corrective Action Plan(s) is insufficient to correct the deficiency(ies), further Remedial Action may be required and will be noted by the Department below. In these cases, (which will be noted by REMEDIAL ACTION REQUIRED), the Plan will be required to submit the requested information to the Department within thirty (30) days from the date of the Final Report.

Please refer to Section IV of this Final Report for specific discussion on the status of all deficiencies listed below.

UTILIZATION MANAGEMENT

Deficiency 1: The Plan does not have a mechanism for analyzing encounter data to identify over-/under-utilization, to evaluate appropriateness of care, and to conduct quality assurance studies. [Rule 1300.70 (b)(2)(G)(5)]

UNCORRECTED / REMEDIAL ACTION REQUIRED

Deficiency 2: The Plan does not ensure that emergency dental services are available and accessible. **[Rule 1300.67.2(c)(g)]**

UNCORRECTED / REMEDIAL ACTION REQUIRED

Deficiency 3: The Plan does not adequately demonstrate a mechanism for ensuring the Plan communicates UM processes and criteria to providers, enrollees and the public upon request. **[Rule 1363.5 (a) (c)]**

CORRECTED

ACCESS and AVAILABILITY

Deficiency 4: The Plan has not established a standard for the ratio of Primary Care Dentists to enrollees to reasonably assure that all services offered by the Plan are accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. **[Rule 1300.67.2(d), Rule 1300.67.2.1(a) and (f)]**

[2] Section 1380(i)(2) (2) No later than 18 months following release of the final report required by subdivision (h), the department shall conduct a follow-up review to determine and report on the status of the plan's efforts to correct deficiencies. The department's follow-up report shall identify any deficiencies reported pursuant to subdivision (h) that have not been corrected to the satisfaction of the director.

UNCORRECTED / REMEDIAL ACTION REQUIRED

Deficiency 5: The Plan does not adequately ensure that all enrollees are within 15 miles or 30 minutes driving time of a participating provider. **[Rule 1300.51(d)H(i); Rule 1300.67.2(a) and Rule 1300.67.2.1(a)]**

UNCORRECTED / REMEDIAL ACTION REQUIRED

Deficiency 6: The Plan has not established requirements for the hours of operation and the minimum hours of appointment time for participation as a Primary Care Dentist provider. **[Rule 1300.67.2(b)]**

UNCORRECTED / REMEDIAL ACTION REQUIRED

GRIEVANCES and APPEALS

Deficiency 7: The Plan does not have a policy for ensuring that adverse coverage grievance determination letters clearly specify the provision in the contract that excludes the coverage. **[Section 1368(a)(4]**

UNCORRECTED / REMEDIAL ACTION REQUIRED

Deficiency 8: The Plan does not adequately demonstrate that it has a process and the mechanism within its grievance system for ensuring that there are procedures for identifying and handling the expedited review of grievances. **[Rule 1300.68.01(a) and (b)]**

CORRECTED

Deficiency 9: The Plan does not have a written policy and procedure in place to ensure adequate consideration of enrollee grievances and rectification when appropriate. [**Section 1368(a)(1)]**

UNCORRECTED / REMEDIAL ACTION REQUIRED

Deficiency 10: The Plan does not have an established system to receive Department contacts regarding urgent grievances twenty-four-hours a day, seven-days a week. **[Rule 1300.68.01]**

UNCORRECTED / REMEDIAL ACTION REQUIRED

Deficiency 11: The Plan does not maintain a policy and procedure to ensure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) solely on the grounds that the enrollee filed a complaint. **[Rule 1300.68(b)(6)]**

UNCORRECTED / REMEDIAL ACTION REQUIRED

QUALITY MANAGEMENT

Deficiency 12: The Plan does not have network-wide information systems that provide staff and the QA Committee with encounter data/utilization data and/or clinical data to perform quality assurance activities. **[Rule 1300.70(a)(3] Repeat Deficiency from Follow-Up Report of April 27, 2002**

UNCORRECTED / REMEDIAL ACTION REQUIRED

Deficiency 13: The Plan does not have written policies and procedures to file 805 reports with the appropriate State agencies, to meet the requirements of **California Business and Professions Codes Section 805(b).**

CORRECTED

Deficiency 14: The PrimeCare Provider Manual does not address continuity of care and sharing of information. [**Rule 1300.67.1 (c)]**

UNCORRECTED / REMEDIAL ACTION REQUIRED

Deficiency 15: The Plan does not perform any of the following activities in order to adopt preventive care standards and promote the use of preventive care services: **[Rule 1300.70(b)(2)(G)(5) and (6)]**

- Developing dental preventive care guidelines for all age groups with input from participating dentists;
- Distributing its preventive dental care guidelines to its enrollees annually;
- Regularly informing its enrollees about the importance of healthy behaviors and the availability of oral health education materials.

UNCORRECTED / REMEDIAL ACTION REQUIRED

Deficiency 16: The Plan does not have the following credentialing policies and/or procedures. **[Section 1367(b) and Rule 1300.67.2(e)] Repeat Deficiency from Follow-Up Report of April 27, 2002**

- Written policies and procedures that specify the credentials that a dentist must have to be part of the Jaimini Network.
- Policies and procedures that govern the credentialing process, including specifying the role of the Director of Provider Relations, the Dental Director, and the Quality Assurance Committee.
- A requirement that specialists be board-eligible or board-certified or verify the board status of the specialists in the network.
- Procedures to assure that it credentials all associate dentists in the offices with which it contracts and that the offices notify the Plan when associates leave the practice.

UNCORRECTED / REMEDIAL ACTION REQUIRED

Deficiency 17: The QM program does not have a documented process for identifying, investigating, and resolving potential quality-of-care issues that occur in all treatment settings. **[Rule 1300.70(a)(1) and (3)]**

CORRECTED

IV. DISCUSSION OF DEFICIENCIES, FINDINGS, AND CORRECTIVE ACTIONS

UTILIZATION MANAGEMENT

Deficiency 1: **The Plan does not have a mechanism for analyzing encounter data to identify over-/under-utilization, to evaluate appropriateness of care and to conduct quality assurance studies.** [Rule 1300.70 (b)(2)(G)(5)]

Citation*:*
Rule 1300.70(b)(2)(G)(5):
Ensure that for each provider the quality assurance/ utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.

Discussion of Findings:
The Plan maintains separate databases for Healthdent and PrimeCare utilization data. The Healthdent utilization data are entered into an EXCEL spreadsheet and include procedures performed by the provider. The PrimeCare encounter data are entered into HMO Pro, which produces reports that identify service type, number of services, chair time and co-payments. The Department concluded that, while this information is useful for rate evaluation, it is not sufficient to analyze individual utilization patterns, network trends and appropriateness of care for the enrollee population.

The Plan's Director of Provider and Member Services is responsible for entering and reviewing the individual encounter forms. The Director stated that inappropriate utilization is identified subjectively at the time the encounter data are entered into the computer system and the determination of treatment appropriateness is based on undocumented criteria. The Dental Director stated that "network norms" have not been established.

The Chief Operating Officer submits a summary statement regarding encounter information and the aggregate number of specialty referrals to the QAC on a quarterly basis as evidenced in the QAC meeting minutes. The QAC meeting minutes consistently state that utilization data "are reviewed for over- or under-utilization and correctness of co-payments. This over- and under-utilization is based on a comparison of network providers against the network as a whole."

The PCD is required to submit a separate encounter form on a monthly basis that identifies individual enrollee referrals to specialists and the specialist type. While the encounter information identifies the number of enrollee referrals by specialty type, there is no formal process for evaluating specialty referral patterns and rates by an individual primary care dentist. The data reported are not substantiated by statistical analysis, evaluation of performance goals or summarization of the monthly encounter data submitted by providers. Utilization data are not evaluated to determine whether there are potential barriers to care and whether enrollees are receiving appropriate preventive dental services.

The Chief Operating Officer stated that the Plan would be able to perform better analyses once the Healthdent data are also entered into the HealthPro system. Although the Plan anticipated converting to the HealthPro system in order to input the Healthdent data in January 2002, the conversion has not yet taken place and the Plan does not have a new anticipated completion date.

Corrective Action 1:
The Plan shall submit documented evidence to demonstrate that it has established standards and performance goals for its quality assurance indicators. The Plan shall submit documented evidence that it has revised its utilization data review process to include a review of quality assurance indicators, such as procedures by providers, specialty referrals by providers and specialist types and number of enrollees in each provider facility. The Plan shall submit documented evidence to demonstrate that it is analyzing this information and comparing it against the Plan's standards.

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response
   Jaimini Health is a relatively small plan and it is very difficult to achieve meaningful results when conducting sophisticated utilization analysis on such a small number of members. As the Plan grows in numbers, the Plan's utilization program will continue to grow in sophistication. The current utilization report shows the number of proxy, sealants, restorations and specialty referrals by provider.

2. Plan's Response to DMHC's Required Actions/Recommendations
   Jaimini Health has modified the Plan's utilization standards as outlined in the Quality Assurance Manual. Additionally, the Plan is taking to its Quality Assurance Committee Meetings recommended standards and performance goals for its quality assurance indicators. These approved standards and evidence of utilization analysis will be submitted to the DMHC at a date specified below.

3. Plan's Corrective Action and Documentation
   Jaimini Health has modified the Plan's utilization standards as outlined in the Quality Assurance Manual.

4. Plan's Corrective, Documentation and Action Time Line
   a. The Plan is taking to its Quality Assurance Committee Meeting on March 27, 2003 recommended standards and performance goals for its quality assurance indicators. These will be submitted to the DMHC by June 1, 2003.

b. Documented evidence to demonstrate that it is analyzing this information and comparing it against the Plan's standards will be submitted for the first quarter of 2003 to the DMHC by June 1, 2003.

Department's Finding Concerning Plan's Compliance Effort:
The Plan demonstrates compliance with establishing standards for resource utilization as seen in the QA Manual section on Monthly Utilization Reports on page 16. The Plan sets standards for proxies, exams, restorations, and referrals for providers with more than 250 assigned members.

The Plan has not revised the utilization data review process. The Plan intends to submit evidence to demonstrate that it is analyzing utilization data and comparing it against established standards.

STATUS: ***NOT CORRECTED***

Remedial Action Required:
The Plan shall submit evidence that it has revised its utilization data review process. The Plan shall submit evidence to demonstrate that it is analyzing utilization data and comparing it against established standards.

Deficiency 2: **The Plan does not ensure that emergency dental services are available and accessible.** [Rule 1300.67.2(c)(g)]

Citation*:*
Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;

Rule 1300.67.2(c):
Emergency health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week.

Citation*:*
Rule 1300.67.2(g)
A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the needs of such enrollees for such information regarding that plan or area.

Discussion of Findings:
The Plan's provider contracts, require that the PCD arrange for emergency services to be available 24 hours a day, 365 days per year, including vacation periods and other times that a provider's office(s) may be closed. Such arrangements are at the expense of the provider. One identification card (ID) per family is distributed to the enrollee upon receipt of the premium by the Plan. The ID card directs the enrollee to contact his or her PCD at the phone number listed on the front of the card. If the enrollee is unable to reach the PCD, the enrollee is instructed to call the Plan for instructions. If emergency care is needed after hours and neither the Plan nor the primary care provider is available, the policy states that the enrollee may seek emergency

dental care from any licensed dentist. The card further states: "Please refer to your Certificate of Coverage and Plan Schedule."

In reviewing the documentation for emergency services, the Department determined that the Plan has different geographic radius requirements, reimbursement limitations and definitions for Healthdent and PrimeCare, as shown above in Table 1: Emergency Care. The Plan officers stated during an interview that they were not aware of the variations in the provider and enrollee language and the geographic limitations. They stated the Plan is in the process of merging the Healthdent and PrimeCare documents to reflect the Jaimini policies but they were unable to provide a completion date.

The Plan does not reimburse the enrollee or the dentist for any in-area routine or emergency care. The Plan's QA Manual (Page 15) and the Healthdent Provider Manual (page 22) describe the following reimbursement policies under Emergency Services: "If outside the geographical area of the enrollee's PCD (more than a 30-mile radius), an eligible enrollee will be reimbursed for emergency treatment up to a maximum of $50. If, however, the enrollee was within a 30-mile radius and the enrollee's PCD was not available, the Plan will reimburse the enrollee an amount that represents the difference between charges for emergency services and the Plan co-payments for the same treatment." There is no limit on the number of emergency room visits for which the enrollee can receive reimbursement in one year.

For PrimeCare, there is no provider information in the Provider Handbook on reimbursement for emergency services. The PrimeCare EOC and Group Provider Agreement state that the reimbursement for emergency services provided by a non-participating provider located more than 50 miles from a selected provider is "up to $50 per year, per member." The Plan indicated that it was not aware of the difference in the reimbursement for emergency services between Healthdent and PrimeCare.

The Department is concerned that:

- Limiting the reimbursement of services to a maximum of $50 for out-of-area emergency care for both products can be a barrier to receiving emergency services, unless the Plan can demonstrate that the average difference between what an enrollee pays for out-of-area emergency services and what the enrollee would have paid for the same services from the PCD is $50;
- The PrimeCare annual $50 limitation per enrollee per year can serve as an unreasonable limit on reimbursement for out-of-area emergency services;
- The Plan is deficient in not addressing in the PrimeCare product, how it will reimburse enrollees for emergency services they received from a nonparticipating provider when their PCDs were not available; and
- The 30-mile and 50-mile limits used to define out-of-area services pose a potential barrier to receiving emergency services since enrollees may have no reasonable way to know their exact geographic distance from a provider.

Corrective Action 2:
The Plan shall submit the following to the Department:

- Evidence that the maximum reimbursement of $50 to enrollees for out-of-area emergency services represents the difference, on average, between what an enrollee pays for out-of-area emergency services and what the enrollee would have paid for the same services from the PCD;
- Evidence that the PrimeCare annual emergency reimbursement limit of $50 per enrollee per year is not a barrier to care; and
- Evidence that the 30-mile and 50-mile limits that define when the enrollee must seek care from his or her PCD is not a barrier to seeking services.

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response
   The $50 reimbursement for out-of-area emergency care was approved by the Department in the Plan's filing, as well as, the mileage requirement for both Healthdent and PrimeCare.

2. Plan's Response to DMHC's Required Actions/Recommendations
   A review of procedures shows that the average emergency palliative treatment costs at a member's PCD is $20 to $50 and the same procedures performed by a non-network dentist would range $70-$100. Therefore, the $50 reimbursement should not be a barrier to accessing emergency care when out-of-area.

   Jaimini Health has not received any grievances for either the Healthdent or PrimeCare products with respect to out-of-area emergency services/costs. Nor has Jaimini Health received any grievances concerning PrimeCare's limitation of $50 per enrollee per year.

   Jaimini Health has not received any complaints concerning the mileage requirements for seeking care from his or her PCD.

3. Plan's Corrective Action and Documentation
   No corrective action required, see #2 above.

4. Plan's Corrective, Documentation and Action Time Line
   No corrective action required, see #2 above.

Department's Finding Concerning Plan's Compliance Effort:
The Plan claims that a "review of procedures" demonstrates that the $50 reimbursement is indeed equal to the difference between in-network and out-of-network emergency palliative treatment costs. The Plan provides no documentation to substantiate this claim.

The Plan claims to have had no grievances regarding the annual $50 per enrollee limit for emergency out-of-area reimbursement. It is not sufficient to rely on the grievance process to rule out a real or perceived barrier to emergency dental care. The Plan has failed to demonstrate that the reimbursement limit for emergency dental services is not a barrier to care.

The Plan claims to have had no complaints regarding the mileage limitation for seeking in-network emergency dental care. It is not sufficient to rely on the complaint process to rule out a

real or perceived barrier to emergency dental care. The Plan has failed to demonstrate that the defined mile limit for emergency dental services is not a barrier to care.

STATUS: ***NOT CORRECTED***

Remedial Action Required:
The Plan shall submit a copy of its filing(s) for the $50 reimbursement for out-of-area emergency care and the mileage requirements for both Healthdent and PrimeCare, and a copy of the Department's written notice(s) of approval to the Plan.

The Plan shall provide documentation to substantiate that the $50 reimbursement is equal to the difference between in-network and out-of-network emergency palliative treatment costs.

The Plan shall demonstrate that emergency dental services are at all times available to enrollees regardless of location or reimbursement limitations. The Plan shall demonstrate that the annual $50 per enrollee limit for emergency out-of area reimbursement and the 30/50-mile radius requirement for obtaining services at the in-network provider do not prevent enrollees from receiving emergency dental services at any time in accordance with prudent layperson rules.

Deficiency 3: **The Plan does not adequately demonstrate a mechanism for ensuring the Plan communicates UM processes and criteria to providers, enrollees and the public upon request.** [Rule 1363.5 (a) (c)]

Citation:
Rule 1363.5(a)
A plan shall disclose or provide for the disclosure to the director (of DMHC) and to network providers the process the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the plan. A plan shall also disclose those processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request.

Citation*:*
Rule 1363.5(c)
The disclosure required by paragraph (5) of subdivision (b) shall be accompanied by the following notice: "The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

Discussion of Findings:
The Plan does not authorize, modify or deny care and there is no evidence of requests for disclosure of the UM processes/criteria. The Plan does not have a written, internal procedure that describes how the Plan would respond to a request for UM information. The Plan indicated that if such disclosures were requested, the person requesting the information would receive the Plan's written clinical guidelines and utilization policies as described in the Plan's QA Manual. However, these materials do not contain language that states: "The materials provided to you are guidelines used by this plan to authorize, modify or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

Corrective Action 3:
The Plan shall submit documented evidence to demonstrate that is has established and implemented policies and procedures that describe the mechanism for ensuring the disclosure of its UM processes and criteria relating to UM decisions upon request by the public, provider(s) or enrollee(s). The Plan shall submit documented evidence that the disclosure contains the following language: "The materials provided to you are guidelines used by this plan to authorize, modify or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response
   The Plan does not authorize, modify or deny care. In order to make this clear in all printed documents, the Plan has added clarifying language to the QA Manual and the Provider Manual.

Department's Finding Concerning Plan's Compliance Effort:
The Plan does not authorize, modify, or deny care. The requirement to disclose the process that the Plan uses to authorize, modify, or deny care is met by appropriate changes to the QA Manual and the Provider Manual.

STATUS: CORRECTED

ACCESS and AVAILABILITY

Deficiency 4: **The Plan has not established a standard for the ratio of Primary Care Dentists to enrollees to reasonably assure that all services offered by the Plan are accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees.** [Rule 1300.67.2(d), Rule 1300.67.2.1(a) and (f)]

Citation:
Rule 1300.67.2(d) *The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees.*

Citation*:*
Rule 1300.67.2.1(a) *If a plan believes that, given the facts and circumstances with regard to any portion of its service area… the standards of accessibility set forth in Section 1300.51(H) and/or*

Section 1367.2 are unreasonably restrictive, the plan may propose alternative standards of accessibility for that portion of the service area. . . (These alternative standards are subject to approval by DMHC.)

Citation*:*

Rule 1300.67.2(f) *Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.*

Discussion of Findings:
The Plan does not have an established standard regarding the ratio of Primary Care Dentists to enrollees. The Plan's pre-site documentation response stated, "75 percent of the Healthdent membership is in the Sacramento region. In that region, the Plan is contracted with 23 offices and 34-contracted dentists. The November 2002 membership is 7,852. Similarly, PrimeCare dental plan has seven southern CA counties with over 100 general dentists. The membership for November 2002 is 4,146." For Healthdent, the Plan presented a report of PCDs by county. For PrimeCare, the Plan presented two reports (General Dental Provider List for May 2002 and a Specialist Provider Listing for July 2001) identifying available providers by county. While the reports define the available contracted providers by zip code and county, the Plan has not reviewed and analyzed these reports to determine enrollee-to-provider ratios.

The Department is concerned that while the Plan has a small enrollment population and has adequate providers based on a network-wide ratio of providers to enrollees, the Plan cannot demonstrate that it has a ratio of PCDs to enrollees on a county basis that reasonably assures that all services offered by the Plan will be accessible to enrollees without delays detrimental to the health of the enrollees.

Corrective Action 4:
The Plan shall submit evidence of an established standard for the ratio of Primary Care Dentists to enrollees that reasonably assures that all services offered by the Plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees, as required by Rule 1300.67.2 (d); or shall propose to the Department an alternate standard, as permitted by Rule 1300.67.2.1(a), by filing a material modification. The Plan shall submit evidence of the mechanism for ensuring that the standards are periodically updated to meet the needs of its enrollees. The Plan shall submit evidence that it periodically measures its PCD network against its standards for the ratio of PCDs to enrollees on a county basis to assure that services are accessible to enrollees.

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response
   The Plan uses the industry standard of one dentist to 2000 members. This is reviewed monthly by the Provider Relations staff as the eligibility reports are generated. As previously stated, Jaimini Health has only eight offices with membership over 250 and none of the offices exceed 850 members.

   Access is monitored through grievances, provider accessibility survey, eligibility reports and facility audits.

2. Plan's Response to DMHC's Required Actions/Recommendations
   See #1 above.

3. Plan's Corrective Action and Documentation
   The Plan has submitted eligibility list and provider accessibility survey.

4. Plan's Corrective, Documentation and Action Time Line
   The Plan will submit in June 2003 a by county analysis of membership verses providers.

Department's Finding Concerning Plan's Compliance Effort:
The Plan claims to use an "industry standard of one dentist to 2000 members." The Plan provides no documentation to substantiate this claim.

The Plan provides documentation, with eligibility reports, that no dentist office has more than 850 enrollees. The Plan does not document that the reports are reviewed on a monthly basis to ensure that no provider exceeds a specified enrollee limit.

The Plan claims to monitor access through the grievance process. The Plan does not document how the grievance process is monitored to ensure timely access to dental care. The Plan states that access is also monitored with provider accessibility surveys and facility audits, but does not supply any evidence to substantiate this claim.

The Plan states that it will submit a county-specific analysis of enrollee-per-provider ratios in June 2003

STATUS: NOT CORRECTED

Remedial Action Required:
The Plan shall submit documentation that it uses a standard of one primary dentist per 2000 enrollees. The Plan shall also provide documentation to substantiate this claim.

The Plan shall submit documentation that enrollment reports are reviewed on a monthly basis to ensure that no provider exceeds the specified enrollment limit.

The Plan shall submit documentation that the grievances are monitored to ensure timely access to dental care. The Plan shall also submit documentation that provider accessibility surveys and facility audits are monitored to ensure timely access to dental care.

The Plan shall submit documentation that it reviews county-specific enrollee-to-provider ratios, and that they are adequate.

Deficiency 5: **The Plan does not adequately ensure that all enrollees are within 15 miles or 30 minutes driving time from a participating provider.** [Rule 1300.51(d) H (i); Rule 1300.67.2(a) and Rule 1300.67.2.1(a)]

Citation:
Rule 1300.51(d)H(i) *Primary Care Providers. All enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider.*

Citation:
Rule 1300.67.2 (a) *The location of facilities providing the primary health care services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility.*

Citation*:*
Rule 1300.67.2.1(a) *If a plan believes that, given the facts and circumstances with regard to any portion of its service area… the standards of accessibility set forth in Section 1300.51(H) and/or Section 1367.2 are unreasonably restrictive, the plan may propose alternative standards of accessibility for that portion of the service area. . . (These alternative standards are subject to approval by DMHC.)*

Discussion of Findings:
The Plan has adopted the accessibility standards, except in rural areas, that "enrollees will normally reside or work within thirty miles or thirty minutes driving time from a Plan provider facility." According to the Dental Director, the Plan has established a geographic standard that, except in rural areas, enrollees reside or work within thirty miles or thirty minutes driving time of a PCD/facility. This standard is different from the regulatory standard that the enrollees work or reside within thirty minutes or fifteen miles of a PCD. The Department reviewed the Plan's filing received July 31, 2001, including exhibits H-1 and I-1, but could not find anything concerning geographic standards. The Plan could not provide evidence that it had submitted a proposal to or received written approval from the Department for alternative standards for the geographic distribution of PCDs within the service area.

According to the Chief Operating Officer, the Plan does not have mapping software that allows it to measure the geographic distribution of PCDs for the Healthdent and PrimeCare products. Therefore, the Plan does not monitor the geographic distribution of PCDs for either product.

The Chief Operating Officer informed the Department that the Plan filed a 2000 Submission of Participation with the Department that identified the Plan's standards for the geographic distribution of enrollees to primary care dentists as 30 miles or 30 minutes driving time of a Plan provider facility. The Plan disclosed that the Department has informally accepted their alternative standards via the 2000 Submission of Participation document. However, the Plan could not provide evidence of this submission to the Department, nor could it offer evidence of written approval from the Department for alternative standards for the geographic distribution of PCDs within the service area.

Corrective Action 5:
The Plan shall submit a corrective action plan demonstrating an established standard for the geographic accessibility of Primary Care Dentists that is consistent with the 15-mile/30-minute requirements of Rule 1300.51H(d)H(i); or, the Plan shall formally propose alternative standards to the Department, consistent with Rule 1300.67.2.1(a). The Plan shall submit documented evidence that it has a mechanism for calculating the geographic availability of PCDs. The Plan shall submit evidence that it periodically measures its PCD network against its standards for the geographic availability of PCDs to ensure that services are accessible to enrollees.

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response
   The Plan's Part VI. Choice of Facilities, B. Accessibility states: "Except in rural areas, members will normally reside or work within thirty miles or thirty minutes driving time from a plan provider facility" was approved by the DMHC.

2. Plan's Response to DMHC's Required Actions/Recommendations

The Plan has already received approval for the alternative standards by the Department. The Plan can manually calculate geographic availability of PCD.

3. Plan's Corrective Action and Documentation
   See #2 above.

4. Plan's Corrective, Documentation and Action Time Line
   In June 2003, the plan will submit evidence that it measures its PCD network against its standards for geographic availability.

Department's Finding Concerning Plan's Compliance Effort:
The Plan's corrective actions are not sufficient to correct the deficiencies. While the Plan reports that the Department has approved its current standard without filing a material modification, it has failed to provide a copy of the written approval from the Department.
.
The Plan claims it can manually calculate the geographic accessibility of primary care dentists and will submit a report to demonstrate that it monitors the geographic accessibility of primary care dentists.

The Plan has not fully implemented all the elements of its corrective action plan at the time of the Plan's response to the Preliminary Report.

STATUS: NOT CORRECTED

Remedial Action Required:
The Plan shall file a material modification with the Department for its alternative access standards. The Plan shall submit a report to demonstrate that it monitors the geographic accessibility of enrollees to primary care dentists.

Deficiency 6: The Plan has not established requirements for the hours of operation, the minimum hours of appointment time and type of after-hours access for participation as a Primary Care Dentist provider. [Rule 1300.67.2(b)]

Citation:
Rule 1300.67.2(b)
Hours of operation and provision for after-hour services shall be reasonable.

Discussion of Findings:
The Plan does not have a specific policy or contractual requirements for the minimum hours of operation for PCD participation. There is a contractual requirement that PCD offices be available during "normal business hours" or "reasonable hours." The provider contract has not specified what constitutes "normal business hours" or "reasonable hours'. The Jaimini Provider Handbook suggests methods that are acceptable for providing after-hours coverage, e.g. an answering service or an answering machine with a dentist's pager number. By contrast, the PrimeCare Provider Handbook does not address acceptable methods for ensuring coverage. The PrimeCare Provider Agreement, 3.8, requires the provider to make available to both Jaimini and enrollees "a twenty-four (24) hour emergency telephone number."

The Plan indicated that provider office hours and access to after hours care are monitored during the periodic facility audit process. This process occurs every one, three or five years depending on the enrollment and the compliance status of the provider.

The Department is concerned that the Plan has not established standards for the hours of operation and the minimum hours of appointment time for participation as a PCD provider. In addition, the Plan's provider documentation does not consistently identify the acceptable methods for ensuring after-hours access to care.

Corrective Action 6:
The Plan shall submit a corrective action plan demonstrating the establishment of a policy for the minimum hours of operation and after-hours coverage for participation as a Primary Care Dentist. The Plan shall file such policies to the Department for approval. The Plan shall also monitor that Primary Care Dentist offices/facilities are compliant with these requirements.

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response
   The Plan has a Microsoft Access database of the facilities that includes the days and hours of operation for each office. This information (days and hours of operation) and information on the after-hours services is confirmed at the time of the facility audit. Additional information about office days, hours of operation, and after-hours services is also collected through the grievance process.

   Further, the Plan contract approved by the Department, Exhibit P-1, Part V. Facilities, Item C. Hours of Operation, Item D. After Hours Service, and Item E. Emergency Hours address these issues.

2. Plan's Response to DMHC's Required Actions/Recommendations
   The Plan is conforming to the regulations since it monitors the reasonableness of hours of operation and provisions for after-hour services through its accessibility survey, grievances and the facility audit tool.

   The establishment of minimum hours of operation for PCD participation does not determine reasonableness nor does it guarantee that Providers meet the Plan's accessibility standards.

   The PrimeCare Provider Handbook is being abolished and the Plan will use one provider handbook based on the current Jaimini Health Provider Handbook. This Handbook suggests methods that are acceptable for providing after-hours coverage, e.g. an answering service or an answering machine with a dentist's pager number.

3. Plan's Corrective Action and Documentation
   The Plan is conforming to the regulations since it monitors the reasonableness of hours of operation and provisions for after-hour services. The establishment of minimum hours of operation for PCD participation does not determine reasonableness nor does it guarantee that Providers meet the Plan's accessibility standards.

4. Plan's Corrective, Documentation and Action Time Line
   See #3 above.

Department's Finding Concerning Plan's Compliance Effort:
The Plan claims to monitor the hours of operation of providers and provision of after-hours services through a self-reported provider survey, grievances, and facility audits. Self-reported surveys are not adequate to determine provider hours of operation unless independently verified.

The Plan claims to monitor hours of operation and after-hours availability through the grievance process. The Plan does not document how the grievance process is monitored to ensure the availability of dental care.

The Plan claims to monitor the hours of operation and after-hours availability with facility audits. The plan does not document how infrequent facility audits ensure the availability of dental care.

The Plan claims that it is not necessary to define the minimum hours of operation because doing so does not "determine reasonableness nor does it guarantee that Providers meet the Plan's accessibility standards." However, the Plan does not have any standard by which to measure reasonable hours of operation, and the Plan cannot ensure the availability of dental care.

STATUS: NOT CORRECTED

Remedial Action Required:
The Plan shall demonstrate and submit evidence that it is actively and regularly monitoring hours of operation and after-hours availability. The Plan shall establish a process to monitor hours of operation and after-hours availability that is independently verifiable, more regular than annual, and proactive, not relying on enrollee complaints or grievances.

The Plan shall define reasonable hours of operation and provide an example of how it determines whether hours of operation are considered to be reasonable or unreasonable.

GRIEVANCES and APPEALS

Deficiency 7: **The Plan does not have a policy for ensuring that adverse coverage grievance determination letters clearly specify the provision in the contract that excludes the coverage.** [Section 1368(a)(4]

Citation*:*
Section 1368(a)(4)
Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan's response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

Discussion of Findings:
The Plan does not pre-authorize services and therefore does not delay, deny or modify health-care services. The Plan has an established system for the review of enrollee grievances. Each telephone or written complaint is reviewed, investigated and resolved by the Dental Director. The Plan does not provide standardized denial reasons within the grievance letters. The Dental Director generates the grievance closure letters and documents the reasons for the determinations in the grievance letters on an individual basis.

During the nine-month period, January through September 2002, the Plan received and processed a total of 26 grievances. The Department reviewed all 26 grievances. Of the 26 files, one was a benefit/quality-of-care issue. The grievance closure letter did not furnish a non-coverage reason that was clear and concise and did not contain the benefit exclusion language. While the Department found only one letter related to a benefit determination, it is concerned that the Plan could not provide evidence of a policy and procedure ensuring that future determinations based in part or in whole on benefit coverage under the enrollee's contract, will cite the benefit exclusion language in the applicable closure letters.

Corrective Action 7:
The Plan shall submit documented evidence of a process and a mechanism ensuring that whenever it issues a determination that the dental service is not a covered benefit under the contract that applies to the enrollee, the communication to the enrollee shall clearly specify the provision in the contract that excludes that coverage.

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response
   In this particular grievance, the member chose to go to an oral surgeon. The provider felt that he could perform the services and did not refer the member. Therefore, the member chose to go outside the plan for services.

   The Plan will amend its grievance letters to include the specific provision in the contract that excludes coverage.

2. Plan's Response to DMHC's Required Actions/Recommendations
   The Plan will amend its grievance letters to include the specific provision in the contact that excludes coverage.

3. Plan's corrective Action and Documentation
   The Plan provides a copy of a sample Grievance Letter with specific provision in the contract that excludes coverage and amended QA Manual.

4. Plan's Corrective, Documentation and Action Time Line
   See #3 above.

Department's Finding Concerning Plan's Compliance Effort:
The Plan demonstrates documentation of a process to ensure that responses to enrollee grievances where the dental service is not a covered benefit clearly specify the provision in the contract that excludes that coverage. The Plan provides a sample revised grievance letter and the revised QA manual. The Plan does not provide any evidence that this process has been implemented.

STATUS: NOT CORRECTED

Remedial Action Required:
The Plan shall submit evidence such as actual copies of grievance letters to demonstrate that it has implemented the process in accordance with the requirement.

Deficiency 8: **The Plan does not adequately demonstrate that it has a process and mechanism within its grievance system for ensuring that there are procedures for identifying and handling the expedited review of grievances.** [Rule 1300.68.01(a) and (b)]

Citation:
Rule 1300.68.01(a) and (b) - *(a)*
Every plan shall include within its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee ("urgent grievances"). At a minimum, procedures for urgent grievances shall include the following:
(1) The plan shall immediately notify the complainant of his/her right to notify the Department of the grievance. (2) The plan shall provide the complainant and the Department with a written statement on the disposition or pending status of the urgent grievance within three (3) days of receipt. (3) The enrollee's medical condition shall be considered when determining the response time. (b) The plan shall establish a system that provides for receipt of Department contacts regarding urgent grievances twenty-four hours a day, seven days a week. During normal business hours, the system shall provide for the plan to contact the Department within thirty (30) minutes following Department contacts regarding urgent grievances. After normal business hours, on weekends or holidays, the system shall provide for the plan to contact the Department within one (1) hour following Department contacts regarding urgent grievances. The system established by the plan shall provide for the availability of a plan representative with authority on the plan's behalf to resolve urgent grievances and authorize the provision of health care services covered under the enrollee's plan contract in a medically appropriate and timely manner. Such authority shall include making financial decisions for expenditure of funds on behalf of the plan without first having to obtain approval from supervisors or other superiors within the plan. Nothing in this subsection shall restrict the plan representative from consulting with other plan staff on urgent grievances.

Discussion of Findings:
The Plan has a written policy for the expedited review process in the QA Manual. The policy states that the Plan "will expedite review of grievances for cases involving an imminent and serious threat to the health of the patient, including but not limited to, severe pain, potential loss of life, or major bodily function . . . inform enrollees in writing of their right to notify the Department… provide the enrollee and the Department with a written statement of the disposition or pending status of the grievance within three days from receipt of the grievance." The Plan's Member Service Representative or another designated Plan staff member is

responsible for receiving and documenting all grievances on the Grievance Log. The grievance is forwarded to either the Grievance Coordinator or the Dental Director who issues the acknowledgment letter. All grievances are forwarded to the Dental Director for review, investigation and resolution.

During the nine-month period, January through September 2002, the Plan received and processed a total of 26 grievances. Of the 26 grievance files, the Department determined that one grievance would have met the expedited review criteria. The subscriber notified the Plan on March 4, 2002 that the enrollee was in pain, had been seen by the PCD and was referred for emergency care to a Pedodontist. The specialist's office informed the subscriber that the specialist could not see the enrollee until March 6, 2002. Based on the file review, the Plan did not identify the case as expedited, did not acknowledge the case until March 7, 2002, and did not resolve the case until March 25, 2002.

While the one case described above does not constitute a trend, the Department is concerned that despite a written policy in its QA Manual that addresses expedited grievances, the Plan did not appropriately identify the case and follow its written procedures for expedited grievances.

Corrective Action 8:
The Plan shall submit documented evidence that it has implemented the procedures in its grievance system for identifying and handling the expedited review of grievances involving an imminent and serious threat to the health of the enrollee ("urgent grievances").

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response
   The Department's reviewer missed some information on this grievance. The member complained about pain not "severe pain" on March 4 and was seen on March 4 by a dentist to alleviate the pain. (The member had this condition for over a year and was directed by the treating dentist to seek care to correct the problem.) The treating dentist referred the member to a specialist. The Plan did expedite this review and grievance was resolved within the three-day timeframe. The Plan was in error for not sending the resolution letter within the required three-day timeframe. The procedures for expedited review have been reviewed with all staff members.

2. Plan's Response to DMHC's Required Actions/Recommendations
   The Plan has documented procedures for expedited reviews in the Plan's QA Manual page 22.

3. Plan's Corrective Action and Documentation
   The Plan provides a copy of the revised QA Manual.

4. Plan's Corrective, Documentation and Action Time Line
   See #3 above.

Department's Finding Concerning Plan's Compliance Effort:
The Plan demonstrates documentation of a process to ensure that responses to enrollee urgent grievances. The Plan provides a revised QA manual with procedures for identifying and

handling the expedited review of grievances involving an imminent and serious threat to the health of the enrollee.

STATUS: CORRECTED

Deficiency 9: **The Plan does not have a written policy and procedure in place to ensure adequate consideration of enrollee grievances and rectification when appropriate.** [Section 1368(a)(1)]

Citation*:*
Section 1368(a)(1) (a)
Every plan shall do all of the following:
(1) …Each system shall provide reasonable procedures in accordance with department regulations that shall ensure adequate consideration of enrollee grievances and rectification when appropriate.

Discussion of Findings:
The Plan's Dental Director has, among other duties, the responsibility of reviewing, investigating and resolving all telephone and written grievances. For each grievance, the Dental Director completes the Grievance Tracking Record with information on enrollee allegations and resolution of the grievance as well as other data. In addition to sending an acknowledgment letter upon receipt of a grievance, the Dental Director sends a response letter outlining the findings and resolution. Plan policy requires that an independent orthodontist auditor review complaints about orthodontic services.

During the nine-month period, January through September 2002, the Plan received and processed a total of only 26 grievances. No appeal was recorded for this period and the Plan currently does not approve, modify or deny care, nor does it pay any specialty or provider claims. Nonetheless, there is no policy or procedure in place requiring a suitable licensed dentist-a dentist who has the appropriate clinical knowledge and expertise and who was not involved in the initial decision-making/denial-to review and make a determination about an appeal or contested claim, in order to ensure adequate consideration of enrollee grievances and rectification when needed.

Corrective Action 9:
The Plan shall submit documented evidence to demonstrate that it has policies and procedures in place specifying that a suitable licensed dentist, who possesses the appropriate clinical knowledge and expertise and who did not participate in the initial decision-making/denial, will perform an appeal review and determination, to ensure adequate consideration of enrollee grievances and rectification when appropriate.

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response
   The Plan will identify an outside licensed dentist who possesses the appropriate clinical knowledge and expertise who does not participate in the initial decision-making/denial to perform an appeal review and determination, to ensure adequate consideration of enrollee grievances and rectification when appropriate.

2. Plan's Response to DMHC's Required Actions/Recommendations

The Plan has modified its QA Manual to reflect this new procedure for appeals.

3. Plan's Corrective Action and Documentation
   The Plan provides a copy of the updated QA Manual.

4. Plan's Corrective, Documentation and Action Time Line
   See #3 above.

Department's Finding Concerning Plan's Compliance Effort:
The Plan demonstrates documentation of a process to ensure that a suitable licensed dentist, who possesses the appropriate clinical knowledge and expertise and who did not participate in the initial decision-making/denial, will perform an appeal review and determination, to ensure adequate consideration of enrollee grievances and rectification when appropriate. The QA Manual is revised to reflect the policy and procedure. The Plan does not provide evidence that this process has been implemented

STATUS: NOT CORRECTED

Remedial Action Required:
The Plan shall submit evidence such as the name, credentials, and written agreement(s) of the independent reviewer(s).

Deficiency 10: **The Plan does not have an established system to receive Department contacts regarding urgent grievances twenty-four-hours a day, seven-days a week.** [Rule 1300.68.01]

Citation:
Rule 1300.68.01 (b) *requires in part that the plan shall establish a system that provides for receipt of Department contacts regarding urgent grievances twenty-four hours a day, seven days a week. During normal business hours, the system shall provide for the plan to contact the Department within thirty (30) minutes following Department contacts regarding urgent grievances. After normal business hours, on weekends or holidays, the system shall provide for the plan to contact the Department within one (1) hour following Department contacts regarding urgent grievances.*

Discussion of Findings:
The Plan does not have a system to receive Department contacts regarding urgent grievances twenty-four hours a day, seven days a week. Plan officials reasoned that the Plan currently does not approve, modify or deny care nor does it pay any specialty or provider claims. Therefore, it is the opinion of the Plan that it does not need to establish a system that provides for the receipt of the Department (DMHC) contacts. The Department pointed out that grievances might arise from other circumstances, such as an enrollee not being able to obtain emergency services from his/her PCD or another participating dentist. In this situation, the enrollee may be prompted to contact the Department, which in turn contacts the Plan. Without any established system for the receipt of Department inquiries/contacts, the Plan will not be in a position to respond promptly and efficiently.

Corrective Action 10:
The Plan shall demonstrate that it has implemented a system, such as an on-call system, by which it can receive Department contacts regarding urgent grievances twenty-four hours a day, seven days a week.

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response
   The Plan was informed by Brian Bartow of the Department of Managed Health Care that since the Plan did not approve, modify or deny care nor does it pay any specialty or provider claims that it did not need to have in place a twenty-four hours a day, seven-days per week contact. In cases of a dental emergency, members are notified on their cards and in their contracts how to handle those cases. Additionally, the Plan has a night message that informs members how to handle emergency situations. There are no additional services that the Plan could provide with a live person available 24/7.

Department's Finding Concerning Plan's Compliance Effort:
The Plan states that the Department has exempted the Plan from this requirement because the Plan does not approve, modify, or deny enrollee dental care. The Department requires the Plan to comply with all the applicable requirements of the Knox-Keene Act. The Plan is required to have a mechanism for the Department to communicate urgently with a Plan representative in case the Department needs to urgently process an enrollee grievance.

STATUS: NOT CORRECTED

Remedial Action Required:
The Plan shall implement a mechanism for the Department to communicate around the clock with a Plan representative in case the Department needs to urgently process an enrollee grievance. If the Plan wishes, it may either submit a copy of the written exemption it states it received from the Department or the Plan may submit a material modification to request an exemption.

Deficiency 11: **The Plan does not maintain a policy and procedure to ensure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) solely on the grounds that the enrollee filed a complaint.** [Rule 1300.68(b)(6)]

Citation*:*
Rule 1300.68(b)(6)
The plan shall assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) solely on the grounds that the enrollee filed a complaint.

Discussion of Findings:
There are several Plan documents that contain an enrollee discrimination clause as described in the Table 5 below:

Table 5 – Discrimination Clause Statements

PrimeCare Evidence of Coverage and Disclosure Form	The Healthdent Group Subscriber/Individual Plan Contract	Dental Provider Agreement
"The Plan will not discriminate against any enrollee based on age, race, religion, national origin, sex, or sexual orientation."	"Neither the Plan nor any provider shall discriminate against any person seeking coverage for general dentistry services under this Agreement because of race, color, national origin, …or physical or mental disability."	"Provider assures that Services shall be provided to Enrollees in the same manner as such Services are provided to other patients. Provider shall not unlawfully discriminate against any Enrollees on the basis of source of payment…. Provider shall not unlawfully discriminate against any Enrollee, employee or applicant for employment on the basis of race, religion, …"

There are no statements or guidelines in the above Plan documents along with other documents reviewed specifying no discrimination against an enrollee or subscriber (including cancellation of the contract) solely on the grounds that the enrollee filed a complaint.

Corrective Action 11:
The Plan shall submit evidence to demonstrate that it has established and implemented policies and procedures to ensure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) solely on the grounds that the enrollee filed a complaint.

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response
   This must have been an oversight of the reviewer. Page 32 of the Provider Handbook states: "JAMINI HEALTH will ensure that no discrimination shall exist against an enrollee solely on the grounds that such person filed a complaint".

2. Plan's Response to DMHC's Required Actions/Recommendations
   The Plan has this language in the Provider Handbook. The Plan provides a copy of page 32, second bullet, which has the required language.

Department's Finding Concerning Plan's Compliance Effort:
The Provider Handbook states that, "JAMINI HEALTH will ensure that no discrimination shall exist against an enrollee solely on the grounds that such person filed a complaint." This statement does not demonstrate that the Plan has implemented policies and procedures to ensure that there is no discrimination against an enrollee or subscriber solely on the grounds that the enrollee filed a complaint.

STATUS: NOT CORRECTED

Remedial Action Required:
The Plan shall submit evidence to demonstrate that it has actually established and implemented policies and procedures to ensure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) solely on the grounds that the enrollee filed a complaint. This shall include timely written notification to all enrollees that the Plan ensures there is no discrimination by the Plan against an enrollee or subscriber (including cancellation of the contract) solely on the grounds that they filed a complaint. The Plan shall

QUALITY MANAGEMENT

Deficiency 12: **The Plan does not have network-wide information systems that provide staff and the QA Committee with encounter data/utilization data and/or clinical data to perform quality assurance activities.** [Rule 1300.70(a)(3)] **Repeat Deficiency from Follow-Up Report of April 27, 2002**

Citation*:*
Rule 1300.70(a)(3) *requires that "A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meet professionally recognized standards of practice****."***

Discussion of Findings:
The Plan does not underwrite any dental services other than the $50 emergency service reimbursement for both products and the $50 initial consultation fee for the Healthdent product, both of which are paid directly to the consumer. Therefore, it does not process any claims that would generate utilization or encounter data. To address the need for utilization and encounter data, the Plan requires both Healthdent and PrimeCare dentists to submit encounter logs that identify any dental services provided to enrollees.

The Plan's Chief Operating Officer provided sample reports to confirm that the Plan is using this data. However, these reports were simply lists of services provided by service code. They did not provide information that could be used for utilization management or quality purposes. Thus, the Plan cannot currently carry out any practitioner-specific or population-based quality assurance activities.

Corrective Action 12:
The Plan shall submit documented evidence that it has put in place information systems that provide data for both the Healthdent and PrimeCare products on an ongoing basis to Plan staff and the QA Committee regarding the quality of care and service provided to enrollees. This can be done by using data from the encounter logs submitted by participating dentists and/or on-site data from the general dentist and orthodontist office surveys.

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response
   Please see Plan's Response to Deficiency #1 under Utilization Management.

2. Plan's Response to DMHC's Required Actions/Recommendations
   Please see Plan's Response to Deficiency #1 under Utilization Management.

3. Plan's Corrective Action and Documentation
   The Plan provides a sample Utilization Management form to be used by QA Committee.

4. Plan's Corrective, Documentation and Action Time Line
   See #3 above.

Department's Finding Concerning Plan's Compliance Effort:
The Plan submits a sample Utilization Management form to be used by the QA Committee. The Plan provides no indication as to how the form will be used to improve quality of care. The Plan does not address the issue of data collection and data reliability. There is no general program to improve the quality of dental care for enrollees.

STATUS: NOT CORRECTED

Remedial Action Required:
The Plan shall demonstrate and provide evidence that it collects useful and reliable data. The Plan shall demonstrate that it analyzes the data, identifies areas for improvement, formulates corrective actions, implements corrective actions, and then re-measures and re-analyzes the data to determine whether the corrective actions were effective.

Deficiency 13: The Plan does not have written policies and procedures to file 805 reports with the appropriate State agencies, to meet the requirements of California Business and Professions Codes Section 805(b).

Citation:
Section 805 (b) of the California Business and Professions Codes *requires that "The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an* ***805*** *report with the relevant agency whenever any of the following actions are taken as a result of a determination of a peer review body: (1) A licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason. (2) A licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason. (3) Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason. In addition to the duty to report as set forth in paragraphs (1), (2), and (3), the peer review body also has a duty to report under this section a licentiate's resignation or leave of absence from membership, staff, or employment following notice of an impending investigation based on information indicating medical disciplinary cause or reason. The* ***805*** *report shall be filed within 15 days after the effective date of the denial, termination, restriction, resignation, or leave of absence, or after the exhaustion of administrative procedures, without regard to any filing for judicial review. An* ***805*** *report shall also be filed within 15 days following the imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days. A copy of the* ***805*** *report, and a notice advising the licentiate of his or her right to submit additional statements or other information pursuant to Section 800, shall be sent by the peer review body to the licentiate named in the report. The information to be reported in an* ***805*** *report shall*

*include the name of the licentiate involved, a description of the facts and circumstances of the medical disciplinary cause or reason, and any other relevant information deemed appropriate by the reporter. A supplemental report shall also be made within 30 days following the date the licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as disciplinary action by the reporting peer review body. In performing its dissemination functions required by Section **805.5**, the agency shall include a copy of a supplemental report, if any, whenever it furnishes a copy of the original **805** report. In those instances where another peer review body is required to file an **805** report, a health care service plan or nonprofit hospital service plan is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason.*

Discussion of Findings:
The Plan stated in writing to the Department in 1999 that it would file 805 reports, as appropriate. However, the Plan has not established any written policies and procedures for disciplinary action of practitioners that include internal due process for the practitioner and for submitting 805 reports.

Corrective Action 13:
The Plan shall submit evidence that it has established and implemented policies and procedures to ensure 805 reporting. The policies and procedures must specify the process for reporting and must be consistent with required due process for practitioners and the filing requirements specified in California Business and Professions Codes Section 805(b).

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response
   The Plan has stated in Exhibit J-3 that it will file a report with the relevant agency when a provider is terminated for a medical disciplinary cause or reason, pursuant to the Business and Professions Code or the Health and Safety Code. The Plan has developed specific written policies and procedures to file an 805 report within the QA manual.

2. Plan's Response to DMHC's Required Actions/Recommendations
   See #1 above.

3. Plan's Corrective Action and Documentation
   The Plan provides a copy of the written policies and procedures to file an 805 report, which is within the QA manual.

4. Plan's Corrective, Documentation and Action Time Line
   See #3 above.

Department's Finding Concerning Plan's Compliance Effort:
The Plan has established policies and procedures to ensure 805 reporting. The policies and procedures specify the process for reporting and are consistent with required due process for practitioners and the filing requirements specified in California Business and Professions Codes Section 805(b). The policies and procedures are demonstrated in the QA Manual pages 24-25.

STATUS: CORRECTED

Deficiency 14: The PrimeCare Provider Manual does not address continuity of care and sharing of information. [Rule 1300.67.1 (c)]

Citation:
Rule 1300.67.1 (c) *requires, in part . . . "Within each service area of a plan, basic health care services shall be provided in a manner which provides continuity of care, including but not limited to: (c) The maintenance and ready availability of medical records, with sharing within the plan of all pertinent information relating to the health care of each enrollee.*

Discussion of Findings:
The Healthdent Provider Manual requires that the general care dentist "thoroughly document patient records as to the condition and why treatment was referred to a specialist." The PrimeCare Provider Manual does not address continuity of care and sharing of information.

The Dental Clinical Records Quality Assessment Tool, used by the Dental Director when conducting site surveys, assesses whether the general care dentist, after referring an enrollee to a dental specialist, obtained a report from the specialist.

Corrective Action 14:
The Plan shall submit evidence that PrimeCare-contracted dentists provide for continuity of care and the sharing of pertinent information between the PCDs and specialty care dentists. The Plan shall submit evidence that it has notified, in writing, all PrimeCare contracted dentists of this requirement and has added this information to the current PrimeCare Provider Manual. The Plan shall implement a process to monitor dentists' compliance and shall report findings to the QIC.

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response
   As stated in the Plan's Response for Deficiency 6, the PrimeCare Provider Handbook is being abolished and the Plan will use one provider handbook based on the current Jaimini Health Provider Handbook.

   The audit tool for PrimeCare dentists is the same tool used to audit Healthdent dentists, which assess whether the general care dentist, after referring an enrollee to a dental specialist, obtained a report from the specialist.

2. Plan's Response to DMHC's Required Actions/Recommendations
   See #1 above.

3. Plan's Corrective Action and Documentation
   The Plan will conduct a mailing to all PrimeCare dentists updating their Provider Handbook by June 2003.

4. Plan's Corrective, Documentation and Action Time Line
   See #3 above.

Department's Finding Concerning Plan's Compliance Effort:
The Plan states that it is discontinuing the use of the PrimeCare Provider Handbook. The Plan intends to mail the new Provider Handbook to all network dentists.

The Plan has not fully implemented all the elements of its corrective action plan at the time of the Plan's response to the Preliminary Report.

STATUS: NOT CORRECTED

Remedial Action Required:
The Plan shall demonstrate that it has discontinued the use of the PrimeCare Provider Handbook. The Plan shall demonstrate that it has mailed the new Provider Handbook to all network dentists.

Deficiency 15: **The Plan does not perform any of the following activities in order to adopt preventive care standards and promote the use of preventive care services:**

- **Developing dental preventive care guidelines for all age groups with input from participating dentists;**
- **Distributing its preventive dental care guidelines to its enrollees annually;**
- **Regularly informing its enrollees about the importance of healthy behaviors and the availability of oral health education materials.** [Rule 1300.70(b)(2)(G)(5) and (6)]

Citation*:*
Rule 1300.70(b)(2)(G)(5) and (6) - (5)
Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers. (6) Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.

Discussion of Findings:
The Plan has adopted the California Dental Association's Dental Guidelines, which include general recommendations for preventive care. However, the Department has determined that the Plan has not adopted and disseminated age-specific preventive care services.

Corrective Action 15:
The Plan shall submit evidence of the development, review and approval of dental preventive care guidelines for all age groups, including children, adolescents, adults and older adults. The submission must contain evidence that the guidelines were developed with input from participating dentists. The Plan shall submit evidence to demonstrate that it has distributed its dental preventive care guidelines to its enrollees. The Plan shall submit evidence of its mechanism to ensure that information will be distributed on a regular basis to its enrollees informing them about healthy behaviors and oral health information that is available.

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response

As stated, the Plan has adopted the California Dental Association's Dental Guidelines, which include general recommendations for preventive care. The Dental Director checks the level of preventive services rendered during his chart audits. Additionally, the Dental Director reviews preventive services performed by provider as reported by the provider's submitted utilization.

2. Plan's Response to DMHC's Required Actions/Recommendations
   The Dental Director will develop for review and approval by the QA Committee dental preventive care guidelines for all age groups including children and adults and where applicable, teenagers and older adults. This information will be distributed to enrollees annually.

3. Plan's Corrective Action and Documentation
   The Dental Director will develop for review and approval by the QA Committee dental preventive care guidelines for all age groups including children and adults and where applicable, teenagers and older adults. This information will be distributed to enrollees annually with member card distribution.

4. Plan's Corrective, Documentation and Action Time Line
   The guidelines will be completed by June 2003 and the initial mailing will be completed by October 2003.

Department's Finding Concerning Plan's Compliance Effort:
The Plan states that it uses the California Dental Association Dental Guidelines for preventive care. The Plan states that it will develop dental preventive care guidelines for all age groups including children and adults and, where applicable, teenagers and older adults. The Plan states that it will distribute the dental preventive guidelines to enrollees annually.

The Plan has not fully implemented all the elements of its corrective action plan at the time of the Plan's response to the Preliminary Report.

STATUS: NOT CORRECTED

Remedial Action Required:
The Plan shall develop dental preventive care guidelines for all age groups including children and adults and, where applicable, teenagers and older adults. The Plan shall demonstrate that the guidelines are developed with the input of participating providers. The Plan shall distribute the dental preventive guidelines to enrollees, and the Plan shall demonstrate that there is a mechanism to distribute the guidelines to enrollees on a regular basis.

Deficiency 16: **The Plan does not have the following credentialing policies and/or procedures.** [Section 1367(b) and Rule 1300.67.2(e)]
Repeat Deficiency from Follow-Up Report of April 27, 2002

- **Written policies and procedures that specify the credentials that a dentist must have to be part of the Jaimini Network.**
- **Policies and procedures that govern the credentialing process, including specifying the role of the Director of Provider**

Relations, the Dental Director and the Quality Assurance Committee.

- **A requirement that specialists be board-eligible or board-certified or verify the board status of the specialists in the network.**
- **Procedures to assure that it credentials all associate dentists in the offices with which it contracts and that the offices notify the Plan when associates leave the practice.**

Citation:
Section 1367(b) *requires, in part . . . "All personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law."*

Citation:
Rule 1300.67.2(e) *requires, in part . . . "A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral."*

Discussion of Findings:
The Plan does not have written policies and procedures for assuring that all providers are currently licensed or certified, other than a general description of the credentialing and recredentialing process in the QA Manual. This description states that the credentialing process includes the following:

- Verification of a current valid California dental license
- Query to the National Practitioner Data Bank
- Query to the Health Care Practitioner Data Bank
- Acquisition of copies of Conscious Sedation permits and General Anesthesia permits

The QA Manual also states that the applicant completes a Self-Evaluation Site Survey form. According to the Dental Director and the Director of Provider Relations, the Plan no longer requires the applicant to complete this form. In place of the Self-Evaluation Site Survey form, the Plan now has all applicants review the Quality Assurance Standards for Dental Providers (which are the same as the elements on the Self-Evaluation Site Survey forms) and attest that they are in compliance with the regulations. The Plan, however, does not have a written process for handling applications from dentists that have restrictions on their licenses and/or malpractice or other quality issues on the NPDB query.

According to the Dental Director and the Director of Provider Relations and Member Services, quality issues identified during the credentialing process are forwarded to the Dental Director. The Dental Director reviews the case and makes a determination either to accept or reject the candidate or to take the application to the Peer Review Committee for a decision. However, there are no written procedures for this process.

The Plan does not have any processes to ensure that the specialty dentists that are credentialed for the PrimeCare product are board-eligible or board-certified in the identified specialty for which they will be participating.

The Department reviewed credentialing files to ensure that there was evidence of the Plan's corrective action of May 30, 2002, addressing the previous deficiency for the review of current dental licenses. A review of five credentialing files confirmed that the Plan had verified that the applicant had a current, valid California license at the time of credentialing.

Corrective Action 16:
The Plan shall submit evidence to demonstrate that it has established and implemented a process to ensure the review and approval of credentialing and recredentialing policies and procedures that include the Plan's credentialing criteria, verification processes (including verification of specialty board status) and a description of the roles of the Director of Provider Relations, the Dental Director, the Quality Assurance Committee, and, if applicable, the Board of Directors in the credentialing and recredentialing processes. The recredentialing process should specify how often recredentialing occurs, how credentials are re-verified, whether performance data and/or quality assurance information are used in recredentialing, and if so, what data are used and how they are used. The Plan must also:

- Demonstrate that re- verification of each professional license/certification occurs at each renewal date;
- Submit evidence that each specialty dentist credentialed for the PrimeCare product is currently board-eligible or board-certified in the identified specialty;
- Submit evidence that the Plan has established and implemented a process to ensure that all associates in participating dental offices are credentialed by the Plan prior to providing services to enrollees; and
- Submit evidence that the dental offices notify the Plan when an associate leaves the office.

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response
   The QA Manual indicates what credentials a provider must have to be accepted into the Jaimini Health network. A new section to the QA Manual has been developed that specifies who in the organization is responsible for the credentialing/recredentialing process.

2. Plan's Response to DMHC's Required Actions/Recommendations
   The Plan has developed a new section to the QA Manual that specifies who in the organization is responsible for the credentialing/recredentialing process and when recredentialing occurs.

   Additionally, the Plan has added a section for the dentists that provide specialty services to PrimeCare members. This section outlines that the specialist must be board-eligible or board-certified and that the Plan will confirm the eligibility or certification by the appropriate Board.

   As a part of the quarterly provider accessibility survey, the Plan has added a question concerning the addition or deletion of associate dentists. This information is also identified in the monthly utilization that is processed on a weekly basis.

3. Plan's Corrective Action and Documentation

The Plan provides updated QA Manual pages and updated Provider Accessibility Survey Form.

4. Plan's Corrective, Documentation and Action Time Line
   The evidence for credentialing all PrimeCare specialty dentists will be provided in June 2003.

Department's Finding Concerning Plan's Compliance Effort:
The Plan QA Manual is revised to more clearly describe the initial credentialing process. The QA Manual clearly states the Plan's credentialing criteria, verification processes (including verification of specialty board status) and a description of the roles of the Director of Provider Relations, Dental Director, and Quality Assurance Committee.

The Plan QA Manual is revised to more clearly describe the re-credentialing process. The QA Manual states that re-credentialing occurs on an annual basis. Various performance data such as enrollee complaints, quality reviews, utilization data and provider access reports are to be used in re-credentialing. The Plan does not clearly state how performance data is used in the re-credentialing process.

The Plan QA Manual is revised to include specialist must be board-eligible or board-certified and that the Plan will confirm the eligibility or certification by the appropriate Board at the time of initial credentialing. The Plan implies that it will verify board eligibility or board certification for all current dental specialist providers.

The Plan states that it has a process in place to identify the addition or deletion of associate dentists at participating dentist offices with the quarterly provider accessibility survey.
The revised survey only solicits information regarding additions of associate dentists and does not include deletions. There is no documentation provided as to the process that will be followed when the forms are completed and returned.

The Plan states that it will provide evidence of credentialing all specialty dentists in June 2003.

STATUS: NOT CORRECTED

Remedial Action Required:
The Plan shall clearly state how performance data is used in the re-credentialing process.

The Plan shall demonstrate that it has implemented its new credentialing policy. The Plan shall verify board eligibility or board certification for all current dental specialists and shall monitor the timeliness of its verifications.

The Plan shall track deletions as well as additions of associate dentists in a timely manner. The Plan shall demonstrate that it has a policy and procedure in place for the tracking of additions/deletions of associate dentists.

Deficiency 17: **The QM program does not have a documented process for identifying, investigating, and resolving potential quality-of-care issues that occur in all treatment settings.** [Rule 1300.70(a)(1) and (3)]

Citation*:*
Rule 1300.70(a)(1) and (3) (1)
The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

Discussion of Findings:
The Plan identifies potential quality-of-care issues through enrollee complaints and grievances. There is a general description of the process in the QA Manual, but there are no detailed policies and procedures that describe how quality-of-care issues are investigated.

A review of ten potential quality issue files, all of which arose from enrollee grievances, showed the following:

- All ten issues were handled in a timely fashion;.
- Two of the issues were referred to the Peer Review Committee, one of which the Committee found to be valid and one that they found not to be valid;
- In total, the Dental Director found three issues to be valid quality concerns and seven issues not to be valid quality issues;
- In all ten cases, there was an appropriate response to the enrollee and the provider.

The Department is concerned that while all ten cases were resolved appropriately, the Plan does not have a written process that ensures consistency in the identification and investigation of potential quality-of-care issues.

Corrective Action 17:
The Plan shall submit evidence that it has established a mechanism and a process by which to identify, document, investigate and resolve potential quality-of-care issues that occur in all treatment settings.

Plan's Compliance Effort:
The Plan submitted the following response:

1. Plan's Response
   Although the Plan is doing a good job in identifying, investigating and resolving potential quality-of-care issues that occur in all treatment settings, the Plan agrees that written policies would help ensure consistency should there ever be staff turn-over.

2. Plan's Response to DMHC's Required Actions/Recommendations
   The Plan has developed a written process for the identification and investigation of potential quality-of-care issues.

3. Plan's Corrective Action and Documentation
   The Plan provides a copy of the revised QA Manual.

4. Plan's Corrective, Documentation and Action Time Line
   See #3 above.

Department's Finding Concerning Plan's Compliance Effort:
The Plan revised the QA Manual to clearly document a mechanism and a process by which to identify, document, investigate and resolve potential quality-of-care issues that occur in all treatment settings.

STATUS: CORRECTED

V. OUTSTANDING DEFICIENCIES

This section is presented by the Department to comment on the current status of the Plan's deficiencies, with regard to the previous Final Report of Routine Medical Survey, that remained uncorrected at the time of the Follow-up Review, which was issued on April 17, 2002.

ACCESS AND AVAILABILITY

Initial Deficiency 1: The Plan failed to provide consistent access to care in its Staff Model dental practices. **(Repeat deficiency)**

Citation:
Section 1367(e)(1)– *each health care services plan and, if applicable, each specialized health care service plan shall meet the following requirements: (e)(l) all services shall be readily available at reasonable times to all enrollee. To the extent feasible, the plan shall make all services readily accessible to its enrollees.*

Citation*:*
Rule 1300.67.2 (d) and (f) - (d) *The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees. (f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.*

Further Remedial Action 1 (February 7, 2003 Preliminary Report):
The Plan shall submit documented evidence demonstrating that the adopted accessibility standards are presented consistently in the QA Manual and provider contracts. The Plan shall submit documented evidence that it has a process to ensure that 100% of its provider facilities submit the required provider access data on a timely basis. The process must include actions the Plan will take when providers do not submit data.

Plan's Compliance Effort (in Response to the February 7, 2003 Preliminary Report):
The Plan submitted the following response:

1. Plan's Response
   The QA Manual and the Jaimini Health Provider Manual are used for both Healthdent and PrimeCare dentists. Access standards are discussed on page 25 of the Provider Manual and pages 29 and 30 of the QA Manual.

In addition, the Preliminary Report of Routine Dental Survey dated February 7, 2003 stated "The Plan monitors the submission of the survey tools and reports about a 75% compliance rate with the submission of the provider access information. When providers do not respond, the Plan calls the individual provider for the submission. The submitted data is compiled into the Access Report and reviewed by the Dental Director." The staff records information provided by the dental office when it calls; therefore, the Plan does get 100% response.

2. Plan's Response to DMHC's Required Actions/Recommendations
   Please see #1 above.

3. Plan's Corrective Action and Documentation
   The Plan provides pages from the Provider Manual and QA Manual.

4. Plan's Corrective, Documentation and Action Time Line
   See #3 above.

Department Comments:
The Plan demonstrates that access standards are presented consistently in the QA Manual and Provider Manual. There is no documentation that this applies to provider contracts.

The Plan claims that it calls provider offices when provider access surveys are not submitted. The Plan claims that the response rate on provider access surveys is 100%. There is no documentation that this process actually occurs and that the response rate for provider access surveys is indeed 100%.

STATUS: NOT CORRECTED

Remedial Action Required:
The Plan shall document that access standards are included in provider contracts.

The Plan shall document the process for calling providers who do not respond to provider access surveys. The Plan shall document the monthly response rate for provider access surveys.

Initial Deficiency 2: The Plan continues to lack arrangements with dental providers in parts of the Plan's service area. **(Repeat Deficiency)**

Citation:
Section 1367 (d), (e)(1)– *Each health care services plan and, if applicable, each specialized health care service plan shall meet the following requirements: (d) The Plan shall furnish services in a manner providing continuity of care and ready referral of patients to each provider at all times as may be appropriate consistent with good professional practice; (e)(l) all services shall be readily available at reasonable times to all enrollee. To the extent feasible, the plan shall make all services readily accessible to its enrollees.*

Citation:
Section 1375.1 (a)(2) *Assumed full financial risk on a prospective basis for the provision of covered health care service, except that a plan may obtain insurance or make other arrangements for the cost of*

providing to any subscriber or enrollee covered health care services, the aggregate value of which exceeds five thousand dollars in any year, for the cost of covered health care services provided to its enrollees other than through the plan because medical necessity required their provision before they could be secured through the plan, and for not more than 90 percent of the amount by which its cost for any of its fiscal years exceed 115 percent of its income for that fiscal year.

Citation*:*
Rule 1300.52.4(d) (vii) - (d) *Specific Standards for Notices of Material Modification. If a plan proposes to make any of the following changes, the plan shall file a notice of material modification with the Department: (vii) A change that would have a material effect on the plan or on its health care service plan operations.*

Citation*:*
Rule 1300.67.2(a) *– Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees; (a) The location of facilities providing the primary health care services of the plan shall be within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility; (e) A plan shall provide accessibility to medically required specialists who are certified or eligible for certification by the appropriate specialty board, through staffing, contracting, or referral.*

Citation*:*
Rule 1300.67.4(a) 3(a) *– (a) All subscriber and group contracts and endorsements and amendments shall be printed legibly in not less than 8-point type and shall include at least the following: (a) A benefit afforded by the contract shall not be subject to any limitation, exclusion, exception, reduction, deductible, or co-payment, which renders the benefit illusory.*

Further Remedial Action 2 (February 7, 2003 Preliminary Report):
The Plan shall submit documented evidence of the Healthdent enrollment within all service areas and the availability of general providers within those counties. The Plan shall submit documented evidence of the submission of the material modification to withdraw from areas where the Plan lacks arrangements with providers. The Plan shall submit documented evidence of the material modification to offer an orthodontic benefit in limited areas.

Plan's Compliance Effort (in Response to the February 7, 2003 Preliminary Report):
The Plan submitted the following response:

1. Plan's Response
   The Plan's approved service area constitutes 42 counties not all 58 California counties.

   The Plan was approved to offer orthodontic arrangements by the Department of Corporations (now DMHC) and language that states that orthodontic arrangements are not available in all areas served by Healthdent general dentists was approved in the Plan contract. All member materials, Plan contracts and marketing brochures include this language.

2. Plan's Response to DMHC's Required Actions/Recommendations
   The Plan will submit documented evidence of the Healthdent enrollment within all services areas and the availability of general providers within those counties.

   The Plan was approved to offer orthodontic arrangements by the Department of Corporations and language that states that orthodontic arrangements are not available in

all areas served by Healthdent general dentists was approved in the Plan contract. All member materials, Plan contracts and marketing brochures include this language.

3. Plan's Corrective Action and Documentation
   The Plan will submit documented evidence of the Healthdent enrollment within all services areas and the availability of general providers within those counties.

4. Plan's Corrective, Documentation and Action Time Line
   The Plan will submit documented evidence of the Healthdent enrollment within all services areas and the availability of general providers within those counties by October 2003.

Department Comments:
The Plan reports that its Healthdent service area is 42 counties. The Plan provided a list of the counties in its service area (Appendix C). This list consists of 56 counties (not 42). Seven of the counties listed have no enrollees and no PCDs. Twenty-seven of the counties listed have enrollees but no PCDs. The Plan reports two enrollees in Trinity county with no PCD, but did not include this county on its list. The Plan states that it will submit documented evidence of the Healthdent enrollment within all services areas and the availability of general providers within those counties by October 2003.

The Plan states that the Department of Corporations (now DMHC) approved the Plan contract to offer orthodontic arrangements including language that orthodontic arrangements are not available in all areas served by Healthdent general dentists. Department approval of the Plan contract is not a substitute for a material modification. The Plan did not submit a copy of the material modification.

STATUS: NOT CORRECTED

Remedial Action Required:
The Plan shall submit documented evidence of the Healthdent enrollment within all service areas and the availability of general providers within those counties. For those counties with enrollees that lack PCDs, the Plan shall report the geographical distances to the nearest contracted dentists. If the distance exceeds Plan standards approved by the Department, the Plan shall submit a corrective action plan to the Department. If the Plan feels the standards are too restrictive, it may submit a material modification proposing changes for any portion of its service area.

The Plan shall submit a material modification to the Department concerning its practice to offer an orthodontic benefit in limited areas.

QUALITY MANAGEMENT

Initial Deficiency 5a: The Plan's contracting materials require the provider to report additional and deleted associate dentists via a form provided by the Plan. New associate dentists are also identified by utilization data and enrollee calls. The Plan verifies that the associate's license is current and in good standing. The Plan must provide evidence of a mechanism assuring that the Plan is informed when network offices add or delete associate dentists.

Citation: Section 1367(b) and Section 1370, and Rule 1300.70(b)(1)(A) and (B)
All personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law. Every plan shall establish procedures in accordance with Department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services, and cost. The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are identified, and that follow up is planned where indicated. To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that a level of care which meets professionally recognized standards of practice is being delivered to all enrollees, and quality of care problems are identified and corrected for all provider entities.

Further Remedial Action (February 7, 2003 Preliminary Report):
The Plan shall submit evidence that it has evaluated the effectiveness of the process, identified problems where they existed and implemented corrective action where indicated, ensuring that all personnel employed or under contract with the Plan shall be licensed or certified as required by law. The Plan shall submit the required information to the Department within 30 days of receipt of the Follow-up Survey Report.

Plan's Compliance Effort (in Response to the February 7, 2003 Preliminary Report):
The Plan submitted the following response:

1. Plan's Response
   See response to Corrective Action to Deficiency #16 above.

Department Comments:
See Department Comments for Deficiency #16 above.

STATUS: NOT CORRECTED

Remedial Action Required:
See Remedial Action Required for Deficiency #16 above.

Initial Deficiency 6: The Plan shall file evidence that the Plan has implemented reasonable procedures for continuously reviewing utilization of services of the Plan's network providers.

Citation: Section 1370, and Rule 1300.70(b)(2)(H)(2) and 1300.70(c)
Every plan shall establish procedures in accordance with Department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs. A plan that has capitation or risk-sharing contracts must have a mechanism to detect and correct under-service by an at-risk (as determined by its patient mix), including possible under utilization of specialist services and preventive health care services. In addition to the internal quality of care review system, a plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the Department.

Further Remedial Action (February 7, 2003 Preliminary Report):

The Plan shall submit evidence that quality assurance and utilization data are appropriately analyzed either prior to QAC meetings or by Committee members during the meetings. The Plan shall submit standards and performance goals for its quality assurance indicators. The Plan must submit evidence that data collected during 2001 and the first quarter of 2002 have been analyzed and compared to the Plan's standards and goals. The Plan must submit the required information to the Department within 30 days of receipt of the Follow-up Survey Report.

Plan's Compliance Effort (in Response to the February 7, 2003 Preliminary Report):

The Plan submitted the following response:

1. Plan's Response
   See response to Corrective Action to Deficiency #12 above.

Department Comments:
See Department Comments for Deficiency #1 and Deficiency #12 above.

STATUS: NOT CORRECTED

Remedial Action Required:
See Remedial Action Required for Deficiency #1 and Deficiency #12 above.

A P P E N D I X A

List of Surveyors

The Survey Team consisted of the following individuals:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVE	
Kathy Allen, RN	Associate Health Plan Analyst, DMHC

MANAGED HEALTHCARE UNLIMITED, INC. REPRESENTATIVES	
Rose Leidl, RN, BSN	Project Manager, Team Leader
Bernice Young	Program Director, Grievance and Appeals Surveyor
Linda Occelli	Utilization Management Surveyor
Ruth Martin, MBA	Quality Management Surveyor
Joseph Pennisi, DMD	Clinical Consultant
Lynnette Hutcherson, RN	Access and Availability Surveyor/Case File Reviewer

A P P E N D I X B

List of Staff Interviewed

The following are the key Plan officers and staff that were interviewed during the on-site survey at the Plan's administrative office on December 9 through 12, 2002:

Name	Position
Carolyn Brodt, MPH	Chief Operating Officer
Mohender Narula, DMD	Chief Executive Officer
Cindy Semkiw	Director, Provider Relations and Enrollee Services
Richard White, DDS	Dental Director

A P P E N D I X C

Service Areas

HEALTHDENT OF CALIFORNIA

Counties	
• Alameda	• Nevada
• Alpine	• Orange
• Amador	• Placer
• Butte	• Plumas
• Calavares	• Riverside
• Colusa	• Sacramento
• Contra Costa	• San Benito
• Del Norte	• San Bernardino
• El Dorado	• San Francisco
• Fresno	• San Joaquin
• Glenn	• San Luis Obispo
• Humboldt	• San Mateo
• Imperial	• Santa Barbara
• Inyo	• Santa Clara
• Kern	• Santa Cruz
• King	• Shasta
• Lake	• Sierra
• Lassen	• Siskiyou
• Los Angeles	• Solano
• Madera	• Sonoma
• Marin	• Stanislaus
• Mariposa	• Sutter
• Mendocino	• Tehama
• Merced	• Tulare
• Modoc	• Tuolumne
• Mono	• Ventura
• Monterey	• Yolo
• Napa	• Yuba

PRIMECARE DENTAL PLAN

Southern California	
• Los Angeles	• San Bernardino
• Orange	• San Diego
• Riverside	• Ventura

A P P E N D I X D

List of Acronyms /Glossary

Terms/Acronyms	Definition
ADA	American Dental Association
Endodontics	Endodontics is the branch of dentistry concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention and treatment of diseases and injuries of the pulp and associated periradicular conditions. (ADA - Adopted December 1983)
EOC	Evidence of Coverage
General Dental Services	Dental diagnosis and treatment generally performed by a non-specialized dentist without the use of general anesthesia and not requiring referral to a specialist.
General Practitioner/ General Dentist	A dentist practicing general dentistry who does not hold himself out to be a specialist in a particular filed of dentistry. Also identified as the primary care dentist (PCD).
GSA	Group Subscriber Agreement
QAC	Quality Assurance Committee
Orthodontics	Orthodontics is that area of dentistry concerned with the supervision, guidance and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations of their related structures and the adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex. Major responsibilities of orthodontic practice include the diagnosis, prevention, interception and treatment of all forms of malocclusion of the teeth and associated alterations in their surrounding structures; the design, application and control of functional and corrective appliances; and the guidance of the dentition and its supporting structures to attain and maintain optimum occlusal relations in physiologic and esthetic harmony among facial and cranial structures. (ADA - Definition Adopted December 1980) (Designation Adopted October 1994)
PCD	Primary Care Dentist

Terms/Acronyms	Definition
Pediatric Dentistry	Pediatric Dentistry is an age-defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs. (ADA - Adopted 1995
Pedodontist	A dental specialist that performs pediatric dentistry
Periodontics	Periodontics is that specialty of dentistry which encompasses the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues. (ADA - Adopted December 1992)
Prosthodontics	Prosthodontics is that branch of dentistry pertaining to the restoration and maintenance of oral functions, comfort, appearance and health of the patient by the restoration of natural teeth and/or the replacement of missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes. (ADA - Adopted May 1976)
SCD	Specialty Care Dentist
Specialist	A dental specialist, board certified or board eligible, who is responsible for the specialized dental care of a enrollee in the specific field of endodontics, orthodontics, pedodontics, or oral surgery
Surcharges	Any unauthorized additional fee charged to a subscriber or enrollee for a covered service of the Plan that has not been approved